OVERSIGHT OF AGENCY EFFORTS TO PREVENT AND TREAT DRUG ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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CONTENTS

OVERSIGHT OF AGENCY EFFORTS TO PREVENT AND TREAT DRUG ABUSE

THURSDAY, MARCH 18, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1 p.m., in room 2247, Rayburn House Office Building, John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Barr, Gilman, Shays, Ros-Lehtinen, Souder, LaTourette, Hutchinson, Ose, Mink, Towns, Cummings, Kucinich, Blagojevich, Turner, and Tierney.

Staff present: Robert Charles, staff director; Margaret Hemenway, professional staff member; Amy Davenport, clerk; Michael Yeager, minority counsel; and Courtney Cook, minority staff assistant.

Mr. MICA. I would like to call this meeting of the House Subcommittee on Criminal Justice, Drug Policy, and Human Resources to order; we are pleased to now have with us, Mrs. Mink, our ranking member and other members who have joined us.

We do want to go ahead and get started. We have a full schedule of witnesses. What I would like to do is start with an opening statement and then yield to our ranking member.

Fist of all, I want to thank the ranking minority member, Mrs. Mink, for requesting and helping to facilitate today's hearing. She and her staff have assisted in securing the witnesses that we have here and worked with the majority in preparing for today's hearing.

Again, this is part of, hopefully, a bipartisan effort to deal with a very difficult national issue. We have a wide range of matters to review today with a full panel to discuss a number of critical problems facing our Nation relating to drug abuse and illegal narcotics.

As I have stated many times before, I believe we cannot tackle the problems of drug abuse and the concurrent social problems of crime and significant cost to our country without an approach that addresses simultaneously education, treatment, prevention, enforcement, interdiction, and eradication.

Today's hearing will focus on several key elements that are critical to our total effort. In the past few years, the new majority started its national commitment to solve our growing drug problem.

I believe we have renewed our efforts at education, prevention, and in building effective community coalitions to prevent drug

abuse. While we have dramatically increased spending, any questions relating to effectiveness of programs and results remain.

The administration's drug message, unfortunately, has been marked by ambivalence at the very best. It has supported Needle Exchange Programs. It has downgraded law enforcement and interdiction.

It has, in my opinion, white washed the Mexican Government's drug and corruption problems. It has often fought Congress' efforts to provide proper counternarcotics equipment, which is so important to Columbia.

It has also failed to come to grips with a legalization agenda. Meanwhile, drug use among our young people has doubled over the levels before this administration took office.

In Florida, we have a heroin epidemic. In 1997, 136 Floridians died from heroin overdoses; up from 84 in 1995. The proportion of our Nation's 8th graders who said they have tried heroin doubled between 1991 and 1996.

The administration's answer to the heroin epidemic is not to destroy the crops on the ground in Columbia, which is our major source now of heroin. This is, in my opinion again, the simplest and most cost effective remedy, rather than spend more funds for methadone for heroin addicts.

We will never really win the war against drugs by only treating the wounded. Many of whom will succumb again and again to their addiction and some who will not survive it at all.

Finally, I want to say today how disappointed I am that another $1 million was spent on yet another study of marijuana for medicine. This study has resulted in disappointing news.

The Institute of Medicine report calls for more research, while acknowledging that smoked marijuana should generally not be recommended for medical use, admitting that crude marijuana contains, in fact, very harmful substances.

I am more bothered by the fact that the IOM report seems to be the administration's only response to the medical marijuana ballot initiatives, the assault on Federal Controlled Substances Act, and the FDA approval process for medicines which are deemed safe and effective.

We also know that the potency of today's marijuana is about 10 times greater than what we had around in the 1960's. Between 1992 and 1997, the percentage of 6th, 7th, and 8th graders using marijuana tripled from 4.8 percent to 14.7 percent, according to a PRIDE survey.

I look forward to hearing from NIDA on this, especially because of NIDA's research which has shown that marijuana cigarettes ''prime the brain'' for other illicit drugs. Those drugs often turn out to be cocaine and heroin, as well as from ONDCP's Dan Schecter.

I am concerned because we are witnessing the onset of drug use among younger and younger children. We know from studies that the earlier the onset of use, the longer a drug abuse lasts, the more serious the consequences, and the more addicts we end up seeing on our streets.

Our children are being exposed to a resurgent drug culture, which is much better funded and much more organized than it was 30 years ago. Worse, in my opinion, since many of us believe par-

ents are the most important factor in a child's decision to experiment with illegal drugs.

Almost half the parents today expect their kids to use illegal drugs, and 40 percent believe they have little influence over a child's decision to use drugs. These are some pretty startling statistics.

We have many issues to examine today. I look forward to hearing from our witnesses on how we can improve our Federal programs, how we can provide better services to our States and localities who are struggling with substance abuse, and the staggering cost on individuals, families, schools, and businesses.

Hopefully, our hearing today will provide us with new answers, new solutions, and new hope for what I consider to be one of the most serious problems facing this Nation.

Again, I am pleased with the cooperation of our ranking member, which has allowed us to put together this hearing today and address these issues.

I am delighted at this point to yield to the ranking member, Mrs. Mink for as much time as she may consume.

[The prepared statement of John L. Mica follows:]

Opening Statement of Chairman John L. Mica Subcommittee on Criminal Justice, Drug Policy and Human Resources "Oversight of Agency Efforts to Prevent and Treat Drug Abuse" March 18, 1999

As I have stated many times, I believe that we cannot tackle the problems of drug abuse and the concurrent social problems, crime, and significant costs to our country, without an approach that addresses simultaneously education, treatment, prevention, enforcement, interdiction and eradication.

Today's hearing will focus on several key elements that are critical to our total effort. In the past several years, the new majority restarted our national commitment to solve our growing drug problem.

We have renewed our efforts at education, prevention, and in building effective community coalitions to prevent drug abuse. While we have dramatically increased spending, many questions relating to effectiveness of programs and results remain.

The Administration's drug message has been marked by ambivalence at best. It has supported needle exchange programs; it has downgraded law enforcement and interdiction; it has whitewashed the Mexican Government's drug and corruption problems; it has fought Congress' efforts to provide proper counternarcotics equipment to Colombia; and it has failed to come to grips with the legalization agenda.

Meanwhile, drug use among kids doubled over the levels before this Administration took office.

In Florida, there is a heroin epidemic. In 1997, 136 Floridians died from heroin overdoses, up from 84 in 1995. The proportion of our nation's 8th graders who said they had tried heroin doubled between 1991 and 1996 (NIDA).

The Administration's answer to the heroin epidemic is not to destroy the drug crops on the ground in Colombia (our major source of heroin), which is the simplest and most cost-effective remedy, but rather, more methadone for heroin addicts.

We will never win the war against drugs by only treating the wounded, many of whom will succumb again and again to their addiction and some who will not survive it.

Finally, I want to say how disappointed I am that after $1 million spent on yet another study of marijuana for medicine has resulted in disappointing news-the Institute of Medicine report calls for more research, while acknowledging that smoked marijuana should generally NOT be recommended for medical use, admitting that crude marijuana contains harmful substances.

I'm more bothered by the fact that the IOM report seems to be the Administration's only response to the medical marijuana ballot initiatives, the assault on the Federal Controlled Substances Act and the FDA approval process for medicines which are safe and effective.

We also know that the potency of today's marijuana is about 10 times greater than in 1960. Between 1992 and 1997, the percentage of 6^{th}, 7^{th} and 8^{th} graders using marijuana tripled, from 4.8% to 14.7% (PRIDE Survey).

I look forward to hearing from NIDA on this, especially because of NIDA's research which has shown that marijuana cigarettes "prime the brain" for other illicit drugs such as cocaine and heroin, as well as from ONDCP's Dan Schecter.

I am concerned because we are witnessing the onset of drug use among younger and younger children. And we know from studies that the earlier the onset of use, the longer drug abuse lasts, and the more serious the consequences.

Our children are being exposed to a resurgent drug culture which is much better-funded and better-organized than it was 30 years ago.

Worse, since many of us believe parents are the most important factor in a child's decision to experiment with illegal drugs, almost half of parents today expect their kids to use illegal drugs, and 40% believe they have little influence over a child's decision to use drugs (National Center on Addiction and Substance Abuse).

We have many issues to examine today and I look forward to hearing from our witnesses how we can improve our federal programs, and provide better services to states and localities who are struggling with substance abuse and the staggering costs on individuals, families, schools, and businesses.

Hopefully our hearing today will provide us with new answers, new solutions and new hope for a very serious problem.

Mrs. MINK. I thank you, Mr. Chairman, for yielding to me to make a few opening remarks. I want to especially acknowledge the invitation which you extended to me when I joined this subcommittee to take an active role in helping to put together a substantive discussion about any issue.

Specifically, to help organize this particular hearing today. I appreciate the confidence and courtesy that you have extended to me. In the process of organizing this hearing, I learned a great deal about the whole issue.

Looking to the goals that are posted there on the bulletin board, we see that what we are about to discuss today constitutes a very important part of the overall strategy.

We are talking about demand reduction. We are talking about, in that context, education, prevention, and treatment. Those subject areas are going to be discussed by this panel. The budget request for this strategy is at $17.8 billion. About one-third of it is allocated for activities to reduce the demand.

So, the areas that you will be covering are very, very important and crucial. We do not only want to hear an explanation of what you are doing in your program services in meeting the goals, but we want specifically to find out how effective the programs are, under your administration, and have been or will be with respect to the accomplishment of the goals that are listed in the drug strategy. The people of this country are very concerned about the drug problem.

In my opinion, it is worsening. Much of the problem is within our own communities in terms of the cultivation of marijuana, and the manufacturing of methamphetamine, and other very serious drug substances.

So, the efforts in terms of prevention, treatment, and education are very, very critical. I thank you all for coming. I hope that we will be able to engage in a meaningful discussion this afternoon on this overall subject.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Patsy T. Mink follows:]

Statement of Rep. Patsy T. Mink, Ranking Member
Subcommittee on Criminal Justice, Drug Policy,
and Human Resources
March 17, 1999

Before welcoming our distinguished panel of witnesses, I would first like to thank you, Chairman Mica, for agreeing to hold this important hearing to examine the efforts of our federal agencies in drug prevention, education, and treatment. This is an area centrally important to our drug strategy.

This year, the President requested $17.8 billion for national drug control efforts. Of that amount, about a third - $6.04 billion - is allocated for activities to reduce the demand for illegal drugs. This includes several major increases planned for FY 2000, including an additional $100 million for the Justice Department's Drug Intervention Program, an additional $61 million for Youth Tobacco Prevention program by the Centers for Disease Control and the Food and Drug Administration; an additional $88 million for the Substance Abuse and Mental Health Services Administration for Treatment Capacity Expansion Grants and Substance Abuse Block Grants; and an extra $10 million each for the National Youth Media Campaign and for Drug Courts.

These are increases designed to enhance our demand-reduction program. There are numerous activities undertaken by 45 agencies and agency components dedicated to drug prevention and treatment efforts. We will hear from several witnesses from the drug czar's office, the Department of Health and Human Services, and the Department of Justice.

I am pleased to welcome Dan Schecter, the acting Deputy Director

for Demand Reduction. Mr. Schecter can tell us not only what ONDCP is doing in the National Youth Anti-Drug Media Campaign, Drug Free Communities program, and other activities, but he can give us the big picture and describe how ONDCP is coordinating the efforts of these federal programs. From the Substance Abuse and Mental Health Services Administration, I am pleased to welcome Dr. Joseph Autry, the Deputy Administrator. Accompanying him are Dr. H. Westley Clark, the Director of the Center for Substance Abuse Treatment, and Dr. Karol Kumpfer, the Director of the Center for Substance Abuse Prevention. From the National Institutes of Health, National Institute on Drug Abuse, we have Dr. Richard Millstein, the deputy director. And last, but not least, is Dr. Vicki Verdeyen, the Psychological Services Administrator of the federal Bureau of Prisons. The Bureau of Prisons has the largest budget in the federal government for reducing drug-related crime and the consequences of drug use - $2.06 billion in FY 1999.

So I join the chairman in welcoming you to this subcommittee. I am interested in learning what you do, whether it is working, and whether we are spending our federal dollars in the most effective way possible. There is no question that this drug problem merits this commitment in resources. Drugs cost our society approximately $110 billion each year, and the loss of life and damage to our communities is incalculable. We have to make certain that we are spending our money wisely and that our efforts are making a difference.

I look forward to hearing your testimony today.

Mr. MICA. Thank you.

I am pleased now to recognize the gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

I have no particular opening remarks. I came for the hearing. I appreciate folks showing up and sharing their thoughts with us.

Mr. MICA. OK. Thank you.

We will proceed with our panel this afternoon. Our panel, if I may introduce them, first we have Daniel Schecter, who is the Deputy Director for Demand-Reduction, acting in that position, in the Office of National Drug Control Policy.

Mr. Richard Millstein, who is the Deputy Director of the National Institute on Drug Abuse. He is with the National Institutes of Health.

We have Joseph H. Autry III, M.D., Deputy Administrator of Substance Abuse and Mental Health Services Administration. We have H. Westley Clark, with an M.D., J.D., and M.P.H, Director of the Center for Abuse Treatment, Substance and Mental Health Services Administration.

We have Karol Kumpfer, Ph.D., Director of the Center for Substance Abuse Prevention; and Vicki Verdeyen. She has—is it an educational doctorate?

Ms. VERDEYEN. Yes.

Mr. MICA. OK; good. That is a program I started but never finished, Psychology Services Programs, Federal Bureau of Prisons, with the U.S. Department of Justice.

I would like to welcome our panelists this morning. Ladies and gentlemen, this is an investigations and oversight subcommittee of Congress. So, it is customary that we swear in all of our panelists.

So, if you would please stand, and if you would raise your right hands.

[Witnesses sworn.]

Mr. MICA. They answered in the affirmative. The record will show that. So, pleased to have you with us. We look forward to your testimony this afternoon.

Now, the rules of the game are this in this subcommittee, if you have a long statement, and since we have many witnesses, we will use the clock today. You can submit reams and reams full of information for the record.

We do create a record of this hearing. I would ask that you try to summarize lengthy statements and try to get it into 5 minutes so we can then get into an exchange of questions and discussion.

With that, I am pleased to recognize Daniel Schecter as our first witness, Deputy Director for Demand-Reduction, acting in that position, with the ONDCP.

You are recognized, sir.

STATEMENT OF DANIEL SCHECTER, ACTING DEPUTY DIRECTOR FOR DEMAND-REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY

Mr. SCHECTER. Thank you Chairman Mica, Congresswoman Mink, and other members of this subcommittee. On behalf of all my colleagues, I greatly appreciate the opportunity to have this

hearing on demand reduction. I think we have a good story to tell and all of us are anxious to tell it.

If I could begin on a personal note, I came to ONDCP in 1989 when then the first Director, Bill Bennett, asked me to help him prepare what was then the first National Drug Control Strategy.

As you might imagine, since that time, I have seen, of course, all of the strategies developed; all of the Directors come and go. And I have seen a great deal of progress in demand reduction.

I would like to highlight for you today just a few of the areas that we are quite excited about and to identify what we think are some of the major challenges that lie ahead.

The first point I want to make, which probably almost goes without saying, is that demand reduction has been and will continue to be critical to achieving our goal of lowered drug use in the United States.

It is the cornerstone of the National Drug Control Strategy which Director McCaffrey testified about last month. As you will see, the blue chart lists the five goals of that strategy. Certainly, three of those goals pertain to demand reduction, and various individuals will be referring to those in the course of their testimony.

[Chart shown.]

Mr. SCHECTER. Demand reduction is the cornerstone of our strategy because it works. There is a substantial body of research out there that demonstrates this. We know much more now than we did 10 years ago.

I call your attention in the prevention area, to the little red book that NIDA has produced that identifies research-based prevention strategies.

I urge every member of the subcommittee to take a look at it. We will certainly provide you with copies, if you do not have it.

Drug treatment also works. We have a tremendous body of research now that shows that it is effective in reducing drug use, reducing crime, reducing homelessness, and reducing the cost burden to the American public of drug abuse.

We know demand reduction works because over the last 15 years or so, drug use in this country has been cut substantially. The 1979 household survey shows that 14.1 percent of the population 12 and over were current, active drug users. That is down to 6.4 percent in the 1997 household survey; about a 60 percent reduction in terms of the percentage of the population.

Clearly, this is a substantial achievement and demand reduction strategies have a lot to do with that. Our goal in the Strategy is to cut this by yet another 50 percent by the year 2000.

Now, there are concerns, of course: teen drug use, as you point out Mr. Chairman, has risen through the 1990's. We are gratified, however, that it seems to have stabilized the last 2 years.

We are confident that with some of the new programs being brought on line, teen drug use will be driven down further in the years ahead. There are many reasons for this, but I will cite four.

First, parents are getting more involved and civic and service groups are becoming energized about the drug prevention issue. I note the prevention through Service Civic Alliance that we started with HHS and other agencies, representing about 100 million of

our citizens and, of course, community coalitions sprouting up throughout the country.

Second, Federal resources for demand reduction have increased. In the $17.8 billion fiscal year 2000 request for the entire drug area, there is about $6.04 billion earmarked for demand reduction programs; $2.47 billion for prevention; and $3.57 billion for treatment. Since 1996, treatment funding is up about 26 percent and prevention funding up by over 50 percent.

Third, Federal agencies are working cooperatively better than ever. I can speak with some authority on this; again, having been at ONDCP since 1989.

I have never seen a higher or more effective degree of interagency cooperation. There are many ways I could illustrate this. Certainly, the strategy itself is probably the best indication of that. It is a true team effort.

We have interagency demand reduction working groups at the senior policy level, working on important demand reduction issues. The performance measures of effectiveness [PME] was truly an interagency effort. Over the course of 3 months, we had something like 100 interagency meetings that took place to develop those standards. I will also note the Drug Free Communities Program, which is unusual in that its implementation is a true interagency team effort.

That is something I do not know that I have ever seen in a Federal program. It is interesting that the program itself was created to create partnerships at the local level. We have a partnership at the Federal level with the Justice Department, HHS, and ONDCP implementing that program.

So far, I think this team approach has really proven its worth. The whole is greater than the sum of its parts.

The fourth point I would make is that some important new demand reduction tools are now coming on line, and they are starting to show results. I think over the next couple of years, we will succeed in further driving down rates of teen drug use. The first of these new tools would mention is the media campaign.

I am sure there will be more about this later. This is a historic, unprecedented campaign, more ambitious certainly than anything I have seen in my 27 years of government service.

I think it is changing the face of the drug problem in the U.S. and will continue to do so. We project that by the end of this fiscal year, by the end of September, there will have been 14 million anti-drug messages shown in this country that would not otherwise have been shown to our teens; again, 14 million messages.

We are exceeding the goals that we set for audience reach and message frequency. We are right now reaching over 95 percent of all American teens on an average of once every day with an anti-drug message.

Through the "pro bono match" there have been 47,000 30-second PSAs created by other groups, not created as a part of this campaign, but shown free of charge.

As a result of this campaign, we have major Hollywood television shows now devoting their series programs to anti-drug themes. Home Improvement, ER, Dawson's Creek, and other shows.

I just learned yesterday, that on Channel one, which is a public affairs program piped into American classrooms across the country, they are today showing a town meeting on drugs that was taped yesterday in Los Angeles with General McCaffrey. Over 7 million kids will be watching that today.

Finally, of course I note the superb team of contractors that has been assembled to help the Federal Government implement this campaign; Fleishman Hillard, Ogilvy Mather, Porter Novelli—some of the best people in this business.

A second important new tool is the Drug Free Communities Program. This, again, is an extremely important undertaking. Congress came together in 1997, in a bipartisan fashion, worked with ONDCP and produced what we regard as a flagship piece of legislation.

The first 92 communities were awarded grants last year in 46 States. They are now hard at work. We just completed technical assistance workshops around the country with about 520 prospective new applicants coming and learning how they can put together a good application. We will make a second round of awards later this summer. The final and I think most important new tool, speaking of ONDCP of course—my colleagues will mention some other areas—is the Drug Free Prison Zones Demonstration Program. The $6 million came to ONDCP last year in the appropriations process. We provide $1.5 million to the Bureau of Prisons for Federal correctional institutions and $4 million to eight States to develop new, more effective, innovative ways of keeping drugs out of prisons.

This, of course, is a tremendous problem in jails and prisons throughout the country. These funds are being used to put ion scanners on-line to scan people coming into the prisons for drugs, to train staff, for drug testing of inmates, and a range of other purposes.

Let me mention just a couple of things about the IOM study. Mr. Chairman, you raised it in your opening statement. This was indeed released yesterday. We asked the IOM to do this study back in late 1997.

The reason we asked them to do it was because, at that time, we were in the midst of a series of State referenda which were using the ballot box to make medical policy. We thought that was a bad idea and said so.

To try to refocus the discussion around this issue back onto science where it belongs, we asked the National Academy of Sciences; Institute of Medicine to assemble a blue ribbon team to submit all of the available research on marijuana to the highest possible standards, and then draw some conclusions.

They did, we think, a pretty good job. The study is rigorous. They looked only at peer reviewed literature. They have a distinguished advisory panel.

The first point I would make is—you do not always get these points in reading the news accounts about this study—they distinguished clearly between the cannabinoid compounds in marijuana and smoked marijuana.

Concerning the former, they said, yes, there is definitely some evidence that for certain conditions, some of these compounds show promise of alleviating certain symptoms.

With regard to smoked marijuana, they were quite discouraging about its potential as ever being any kind of useful medication. In fact, they said there is little future for smoked marijuana as medicine.

I would think this would come as bad news for all of those who pushed these State referenda. Finally, they suggest that it might be useful to conduct some clinical trials to develop a more rapid delivery system, including some limited clinical trials of smoked marijuana, but again not for the purpose of proving marijuana is medicine, but to gather important data under very short-term, highly controlled conditions that could be used to develop more rapid and effective delivery systems for the cannabinoid compounds, not for smoked marijuana itself.

Finally, I'd like to identify some future challenges, things which we are eager to work on with the Congress in the months ahead and that we think are very important to the demand reduction effort.

One is we have got to close the treatment gap. We have got to do a better job providing effective treatment to those who need it. Is that my buzzer or your buzzer?

Mr. MICA. Your buzzer went off some time ago. You can wrap that up.

Mr. SCHECTER. I am almost done. We suggest that taking a look at parity legislation might be helpful in this regard. So many people right now are going into the publicly funded treatment system who, quite honestly, probably could have been taken care of by private health insurance, if it were available.

Drug Free Schools Reauthorization is another important challenge coming up. The administration is making some proposals to try to tighten up that program and try to focus it better on the programs that research shows are going to be effective in reducing drug use.

Finally, better integration of drug treatment in the criminal justice system. There is a proposal for a Drug Intervention Program at the Justice Department, which we think is very important. Of course, Bureau of Prisons will have more to say on that later.

Again, I apologize for taking so much time. We look forward to working with the Congress in all of these areas.

[The prepared statement of Mr. Schecter follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Statement by Daniel Schecter
Deputy Director for Demand Reduction (Acting)
Office of National Drug Control Policy
Before the House Government Reform and Oversight Committee,
Subcommittee on Criminal Justice, Drug Policy, and Human Resources.
March 18, 1999

All of us in the Office of National Drug Control Policy thank the Committee for the opportunity to testify today about drug prevention and treatment. Chairman Mica, Representative Mink, distinguished members of the subcommittee, your interest in all aspects of drug control policy and your commitment to bipartisan support of a comprehensive response to the nation's drug abuse problem are much appreciated. We are confident that the *1999 National Drug Control Strategy*, if fully implemented, will reduce illegal drug use and availability by 50 percent by the year 2007.

The *1999 Strategy's* first goal is to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

The *Strategy* focuses on youth for both moral and practical reasons. Children must be nurtured and protected from drug use and other forms of risky behavior to ensure that they grow up as healthy, productive members of society. As youngsters grow, they assimilate what they observe.

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem. To this end, the *Strategy* fosters initiatives to educate children about the real dangers associated with drugs. ONDCP seeks to involve parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign. ONDCP encourages businesses, communities, schools, the entertainment industry, universities, and sports organizations to join these national anti-drug efforts.

Researchers have identified important factors that place youth at risk for drug abuse or protect them against such behavior. Risk factors are associated with greater potential for drug use while protective factors reduce the potential for use. Risk factors include a chaotic home environment, ineffective parenting, anti-social behavior, drug-using peers, general approval of drug use, and the misperception that the overwhelming majority of one's peers are substance abusers. Protective factors include parental involvement; success in school; strong bonds with family, school, and religious organizations; knowledge of dangers posed by drug use; and the recognition by young people that substance abuse by their peers is abnormal behavior, not the common-place, socially acceptable activity they are led to believe.

Goal 3 of the 1999 Strategy – Reduce health and social costs to the public of illegal drug use – focuses on treatment.

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Treatment programs, moreover, can reduce the consequences of addictive drug use on the rest of society. The ultimate goal of treatment is to enable a patient to become abstinent and to improve functioning through sustained recovery. On the way to that goal, reducing drug use, improving the addict's ability to function, and minimizing medical consequences are useful interim outcomes. Treatment options include therapeutic communities, behavioral treatment, medication (e.g., methadone, levo-alph-acetyl-methadol (LAAM), or naltrexone for heroin addiction), outpatient drug free programs, hospitalization, psychiatric programs, twelve-step recovery programs, and treatment that combines two or more of these options.

Providing treatment for America's chronic drug users is both compassionate public policy and a sound investment. For example, the recent Drug Abuse Treatment Outcome Study (DATOS) found that outpatient methadone treatment reduced heroin use by 70 percent, cocaine use by 48 percent, and criminal activity by 57 percent, thus increasing employment by 24 percent. The same survey also revealed that long-term residential treatment achieved similar successes.

SAMHSA's 1997 *Services Research Outcome Study*, the Center for Substance Abuse Treatment's (CSAT's) 1997 *National Treatment Improvement Evaluation Study* (NTIES), the 1994 *California Drug and Alcohol Treatment Assessment* (CALDATA), and other studies demonstrate that treatment reduces drug use, criminal activity, high-risk behavior, and welfare dependency. NTIES' principal conclusions are that:

- Treatment reduces drug use. Clients reported reductions in drug use of about 50 percent in the year following treatment.
- Many types of programs can be effective. Methadone programs, outpatient treatment, and both short- and long-term residential programs reduced drug use among participants.
- Criminal activity declines after treatment. Approximately one half (48.2 percent) of the NTIES respondents were arrested in the year before treatment, but only 17.2 percent were arrested in the year after treatment. Similar decreases were observed among respondents who claimed their primary income source were illegal activities.
- Health improves after treatment. Following treatment, substance abuse-related medical visits decreased by more than 50 percent and in-patient mental health visits by more than 25 percent. So, too, did risk indicators for sexually-transmitted diseases.

- Treatment improves individual well-being. Following treatment, employment rates increased while homelessness and welfare receipts decreased.

The 1994 CALDATA study was a retrospective cost-benefit analysis that examined the cost benefit of treatment services in the state from the perspective of both taxpayers and society. The study found that the department's programs cost taxpayers 209 million dollars in 1992 and yielded benefits of 1.5 billion dollars in reduced crime. The benefits of the programs outweighed the cost by at least four to one.

Demand Reduction Initiatives

The following are some of the key demand reduction initiatives that are underway or planned in the coming year:

National Youth Anti-Drug Media Campaign. The goal of this bipartisan five-year campaign is to use the full power of the media to educate and enable America's youth to reject illegal drugs. This goal includes preventing drug abuse and encouraging current users to quit. There is significant evidence that carefully planned mass media campaigns can reduce substance abuse by countering false perceptions that drug use is normative and influencing personal beliefs that motivate drug use. Media campaigns have been used to prevent or reduce consumption of illegal drugs and smoking along with risky behavior like driving under the influence of alcohol or without seat belts. For all their power to inform and persuade, the media alone are unlikely to bring about large, sustained changes in drug use. The anti-drug campaign will be truly successful only if media efforts are coordinated with initiatives that reinforce one another in homes, schools, and communities.

The anti-drug media campaign began in January 1998 in twelve test sites and was expanded nationwide in July. Once ads began to run in the twelve test sites, anti-drug awareness increased and requests for anti-drug publications increased by more than 300 percent. The campaign harnesses a diverse mix of television, video, radio, Internet, and other forms of new media to deliver anti-drug messages. Messages and channels through which they are being delivered are tailored for specific regional, ethnic, cultural, gender, and age differences among members of the target audiences. Paid and public-service advertising, news, public-affairs programming, and entertainment venues are being used in the media campaign.

ONDCP has assembled a superbly qualified team to assist us in mounting this historic campaign: the Partnership for a Drug-Free America, led by Jim Burke; the Behavior Change Expert Panel, which ensures that all the Campaign's efforts are grounded in science and research; the Advertising Council, which serves as a clearinghouse for public service announcements submitted by non-profit groups for consideration as matching; the American Advertising Federation; and our contractors, Ogilvy & Mather, Fleishman-Hillard, and Porter Novelli.

Currently we are far exceeding our original goals for reach and frequency by reaching 95% of all teens an average of 6.8 times per week. Media outlets are matching paid advertisements with public-service time for advertisements and pro-bono programming content. Public-service advertising space generated by the paid campaign is being dedicated to messages that target underage drinking and smoking, as well as other messages related to the campaign's communications objectives. Since July 1998, over 47,000 30-second television and radio messages -- sponsored by 33 public interest groups -- have aired through the pro-bono match. We have also developed partnerships with a broad range of community and civic groups, professional associations, government agencies, and corporations. In 1998, thirty television programs focused on themes and messages supportive of the campaign. These include episodes of *ER* depicting the dangers of heroin use, *Home Improvement* talking about teen marijuana use, and the *Wayans Brothers* on the risks of using marijuana. We estimate that by the end of this fiscal year, the media campaign will have generated over 14 million anti-drug messages through all media sources.

Expanding Drug-Free Workplaces. Drug-abusing employees affect the productivity of any business; in some industries they pose an obvious threat to the safety and security of Americans. Because of the federal government's example and experience, comprehensive drug-free workplace programs have expanded throughout the nation. Today, over 80 percent of all companies with more than five thousand employees have drug-free workplace programs. Private sector results parallel the federal experience, with rates of positive drug tests decreasing over the past ten years. Clearly, comprehensive workplace programs provide both incentives and models for smaller employers to build upon in coming years. Drug-free employees have fewer work-related accidents and less absenteeism, use fewer health-care benefits, and file fewer workers compensation claims than their drug-abusing colleagues. Recognizing that it is often difficult for small businesses to institute drug-free workplace programs, Congress passed the Drug Free Workplace Act of 1998 that establishes a demonstration program within the Small Business Administration (SBA). Under this program, the SBA will make grants to eligible business development centers to educate businesses on the benefits of a drug-free workplace program, provide technical assistance in establishing programs, and educate working parents on how to keep children drug-free.

Athletic Initiative. Organized athletic programs can reach young people and engage them in drug-free activities. Each year approximately 2.5 million students play football and basketball in high school and junior high. Millions of children are involved in soccer leagues, among other sports. Studies show that a young person involved in sports is 40 percent less likely to get involved with drugs than an uninvolved peer. Scores of children admire professional athletes, but these stars often convey mixed messages pertaining to drugs, if not outright pro-drug attitudes. In 1998, ONDCP launched an Athletic Initiative to reduce drug use within sports, encourage the athletic world to condemn drug use, and urge youth to get involved with sports.

Faith Initiative. The faith community plays a vital role in building social values, informing the actions of individuals and inculcating life skills that are critical to resisting illegal drugs. The clergy -- rabbis, priests, and ministers -- all serve as civic leaders. Many run programs that provide much-needed counseling and drug treatment for members of their communities. Consequently, ONDCP is expanding its outreach to the faith community. In 1999, ONDCP encourages religious communities to speak out against drugs and further develop faith-based initiatives to prevent and treat drug use.

Countering Attempts to Legalize Drugs. Given the negative impact of drugs on American society, the overwhelming majority of Americans reject illegal drug use. Indeed, millions of Americans who once used drugs have turned their backs on such self-destructive behavior. While most Americans remain steadfast in condemning drugs, small elements at either end of the political spectrum argue that prohibition -- and not drugs -- create problems. These people offer solutions in various guises, but one of the most troublesome is the argument that eliminating the prohibition against dangerous drugs would reduce the harm that results from drug abuse. Such legalization proposals are often presented under the guise of "harm reduction." Given concerns about encroaching efforts to justify legalization of harmful psychoactive drugs, the *1999 Strategy* outlines specific steps to counter the potential harm such activities pose.

Countering Attempts to Legalize Marijuana. Marijuana is a Schedule I drug under the provisions of the Controlled Substance Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, because of its high potential for abuse and lack of accepted medical use. Federal law prohibits the prescription, distribution, or possession of marijuana and other Schedule I drugs like heroin and LSD and strictly controls Schedule II drugs like cocaine and methamphetamine. Federal law also prohibits the cultivation of Cannabis sativa, the marijuana plant. Marijuana is similarly controlled internationally through inclusion on Schedule I of the U.N. Single Convention on Narcotic Drugs. In the past decade, data regarding the negative impact of marijuana on our youth has accumulated. As described in Chapter II of the *Strategy*, marijuana use by young people correlates with delinquent and antisocial behavior. The U.S. medical-scientific process has not closed the door on marijuana or any other substance that may offer therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. By law, laboratory and clinical trial data are submitted to medical experts in the Department of Health and Human Services (DHHS), including the Food and Drug Administration (FDA), for evaluation of safety and efficacy. If scientific evidence, including results of adequate and well-controlled clinical studies demonstrates that the benefits of a drug product outweigh associated risks, the substance can be approved for medical use. This rigorous process protects public health. Allowing marijuana or any other drug to bypass this process is unwise. Permitting hemp cultivation would result in de facto legalization of marijuana cultivation because both hemp and marijuana come from the same plant -- Cannabis sativa, which contains THC, the active ingredient in marijuana. Chemical analysis is the only way to differentiate between cannabis variants intended for hemp production and hybrids grown for their psychoactive properties.

On Wednesday, March 17, the National Academy of Sciences' Institute of Medicine (IOM) released their report on marijuana as medicine. ONDCP commissioned the IOM to conduct this study in January 1997. The IOM addressed all issues that ONDCP requested be examined, including: the science base and gaps in scientific knowledge regarding use of marijuana for medical purposes; scientific information about marijuana's mechanism of action; peer-reviewed literature on the uses of marijuana; and costs associated with various forms of the component chemical compounds in marijuana and other pharmacotherapies for special medical conditions. ONDCP appreciates the contribution made by the Institute of Medicine to the debate on the medical efficacy and safety of cannabinoids. We will carefully study the recommendations and conclusions contained in the report, and we will continue to rely on the professional judgement of the Secretary of Health and Human Services, the Director of the National Institutes of Health, and the Surgeon General on all issues related to the medical value of marijuana and its constituent cannabinoids. We note the report's conclusion that "the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology."

Safe and Drug-Free Schools and Communities. The Department of Education's Safe and Drug-Free Schools and Communities Program (SDFSP) provides funds for virtually every school district to support drug and violence prevention programs and to assist in creating and maintaining safe learning environments. The President has announced his intention to overhaul the program to improve its effectiveness. The proposal will require schools to adopt effective drug and violence policies and programs, annual safety and drug use report cards, links to after school programs, and efforts to involve parents. The Department has already implemented principles of effectiveness, which require that all SDFSP-funded programs be research-based. The program is moving in a direction designed to ensure that SDFSP fund recipients, including governors, state education agencies, local education agencies, institutions of higher education, and community organizations, adopt programs, policies and practices that are based on research and evaluation

Mentoring Initiative. This Center for Substance Abuse (CSAP) initiative will implement a national mentoring program to focus on some of the problems young people face, including alcohol and drug abuse. Adult mentors will be recruited and trained to reach at-risk youth in at least four states through demonstration programs. If evaluations prove positive, the program will be expanded to more states by FY 2004.

Youth Substance Abuse Prevention Initiative. Substance Abuse and Mental Health Services Administration (SAMHSA)/CSAP coordinates this HHS-wide initiative that is designed to reduce marijuana use by twelve to seventeen year-olds. Major components of the initiative are regional Centers for the Application of Prevention Technologies (CAPTs) and State Incentive Grants (SIGs). CAPTs provide states and communities technical assistance and information about research-based prevention. SIGs encourage collaboration with private and community-based organizations. Nineteen grants have already been awarded to states.

Youth Tobacco Initiative. The Youth Tobacco Initiative is a multifaceted HHS campaign, coordinated by the Centers for Disease Control and Prevention (CDC). Its purpose is to reduce availability of and access to tobacco and the appeal of tobacco products to youth. The campaign includes funding for tobacco prevention and cessation programs, research, legislative initiatives, regulation, and enforcement.

Youth Alcohol Use Prevention. Alcohol is by far the drug of choice among American youth. National Institute on Alcohol Abuse and Alcoholism (NIAAA) has a number of specific initiatives underway to address youth alcohol use including: Alcohol Screening Day, NIAAA National Advisory Council's Subcommittee on College Drinking, Kettering Foundation National Issue Forums on alcohol, and the Surgeon General's Initiative on Underage Drinking. SAMHSA/CSAP, in collaboration with NIAAA, is supporting a five-year research grant program entitled Effects of Alcohol Advertising on Underage Drinking which explores short- and long-term relationships among youth of exposure to alcohol advertising, alcohol expectancies and other mediating variables, and actual consumption of alcohol by youth.

Closing the Public Treatment System Gap. In 1996, approximately 4.4 to 5.3 million people were estimated to need drug treatment. Slightly less than two million people currently receive drug treatment. Clearly, there is a substantial gap between the number of persons in need of treatment and the number receiving it. One aspect of the Administration's efforts to reduce this gap is the expansion of SAMHSA's Substance Abuse Prevention and Treatment Block Grant. The second component of the federal effort to reduce the public treatment system gap is expansion of the Targeted Capacity Expansion program that makes awards directly to states, counties, cities, and service providers. The goal of this program is to address gaps in treatment capacity by supporting rapid and strategic responses to demand for treatment. Grants will target communities with serious, emerging drug problems as well as communities with innovative solutions to unmet needs. In 1999, these programs will include an HIV/AIDS component targeting minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS.

Expanding Treatment for Adolescents. The need for community-based treatment for troubled teens who are dependent on drugs is particularly great, and there is an even more dramatic shortage of treatment in the juvenile correctional system. There is also a paucity of research-based information about the effectiveness of juvenile treatment. SAMHSA is addressing these problems by evaluating adolescent-focused interventions and providing communities grants for adolescent treatment through its Targeted Capacity Expansion program.

Medications for Drug Addiction. Pharmacotherapies are essential for reducing the number of addicted Americans. Methadone therapy, for example, is one of the longest-established, most thoroughly evaluated forms of drug treatment. The National Institute on Drug Abuse's (NIDA) Drug Abuse Treatment Outcome Study found that methadone treatment reduced participants' heroin use by 70 percent and criminal activity by 57 percent while increasing full-time employment by 24 percent. SAMHSA is conducting a comprehensive review of the current

system for regulating opioid treatment programs (OTPs). The intent is to develop a regulatory proposal that will transfer regulatory oversight from the FDA to SAMHSA, and incorporate accreditation as a requirement for federal approval of OTPs. SAMHSA expects to publish next month a proposed plan for achieving the transition to an accredation-based system. NIDA will continue to fund a high-priority program for discovering new medications to treat drug abuse.

National Drug Abuse Treatment Clinical Trials Network. Over the past decade, NIDA-supported scientists have developed and improved pharmacological and behavioral treatment for drug addiction. However, most of these newer methods are not widely used in practice, because they have been studied only in relatively short-term, small-scale studies conducted in academic settings on stringently selected populations. To reverse this trend and improve treatment nationally, NIDA is establishing a National Drug Abuse Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, multi-site treatment studies in community settings using diverse patients.

Treatment Research and Evaluation. NIDA supports over 85 percent of the world's research on drugs of abuse. Recent research in the area of pharmacotherapies and behavioral therapies for abuse of cocaine/crack, marijuana, opiates and stimulants, including methamphetamine will improve the likelihood of successfully treating substance abuse. In addition, a comprehensive epidemiological system needs to be developed to measure the success of the new therapies. NIDA will conduct clinical and epidemiological research to improve the understanding of drug abuse and addiction among children and adolescents. These findings will be widely disseminated to assist in the development of effective prevention programs.

Improving Federal Drug-Related Data Systems. This initiative will develop a comprehensive data system that adequately informs drug policy makers. It will specifically support the ninety-four targets that constitute the Strategy's PME system. The ONDCP-coordinated Advisory Committee on Drug Control Research, Data, and Evaluation is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system.

Behavioral Treatment Initiative. Behavioral therapies remain the only effective treatment for many drug problems, including cocaine addiction, where viable medications do not yet exist. Furthermore, behavioral intervention is needed even when pharmacological treatment is being used. An explosion of knowledge in the behavioral sciences is ready to be translated into new therapies. NIDA is encouraging research in this area to determine why particular interventions are effective, to develop interventions to reduce AIDS risk behavior, and to disseminate new interventions to practitioners in the field.

Reducing Infectious Disease Among Injection Drug Users. Studies of HIV prevalence among patients in drug treatment centers and women of child-bearing age demonstrate that the heterosexual spread of HIV in women closely parallels HIV among injection drug users (IDUs).

IDUs represent a major public-health challenge. Addicted IDUs frequently have multiple health, mental health, and complex social issues that must be overcome in order to successfully address their addiction, criminal recidivism, and disease transmission problems. NIDA has created a center on AIDS and other Medical Consequences of Drug Abuse to coordinate a comprehensive, multi-disciplinary research program that will improve the knowledge base on drug abuse and its relationship to other diseases through biomedical and behavioral research.

Training for Substance Abuse Professionals. Many health care professionals lack the training to identify the symptoms of substance abuse. Most medical students, for example, receive little education in this area. If physicians and other primary-care managers were more attuned to drug-related problems, abuse could be identified and treated earlier. Many competent community-based treatment personnel lack professional certification. Consequently, SAMHSA/Center for Substance Abuse Treatment (CSAT) has worked collaboratively with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification Reciprocity Consortium/Alcohol and Other Drugs to improve the states' credentialing systems that respect the experiences of individual treatment providers while they earn professional credentials.

Breaking the Cycle of Drugs and Crime. Drug-dependent individuals are responsible for a disproportionate percentage of our nation's violent and income-generating crimes like robbery, burglary, or theft. According to ADAM data, between one-half and three-quarters of all arrestees tested in twenty-three cities around the country had drugs in their system at the time of arrest. About half of those charged with violent or income-generating crimes test positive for more than one drug. In 1997, a third of state prisoners and about one in five federal prisoners said they had committed the offenses that led to incarceration while under the influence of drugs. Nineteen percent of state inmates and 16 percent of federal inmates said they committed their current offense to obtain money for drugs (up from 17 percent and 10 percent, respectively, in 1991). Incarcerating offenders without treating underlying substance-abuse problems simply defers the time when they are released back into our communities to start harming themselves and the larger society. Between 60 and 75 percent of untreated parolees with histories of cocaine and/or heroin use reportedly return to those drugs within three months of release. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by about two-thirds at a fraction of the cost for a prison cell.

The Zero Tolerance Drug Supervision Initiative proposes comprehensive drug supervision to reduce drug use and recidivism among offenders. The federal government will help states and localities implement tough new systems to drug test, treat, and sanction prisoners, parolees and probationers. This initiative will ensure that states fully implement the comprehensive plans to drug test prisoners and parolees that they are required by law to submit to the Justice Department, while also supporting the efforts of states like Maryland and Connecticut to begin drug testing probationers on a regular basis.

The corrections and treatment professions must join in common purpose to break the tragic cycle of drugs and crime by reducing drug consumption and recidivism among individuals in the criminal justice system. We should accelerate the expansion of programs that offer alternatives to imprisonment for non-violent drug law offenders. Treatment must be made more available for drug-dependent inmates and those on probation or parole. Finally, adequate transitional programs should support inmates following detention. The end result will be fewer addicts and drug users, less demand for drugs, less drug trafficking, less drug-related crime and violence, safer communities, and fewer people behind bars. In 1999 the federal government will convene a national summit on substance abuse and criminal justice policy to encourage the expansion by state and local jurisdictions of alternatives to incarceration for non-violent offenders and treatment for drug-dependent offenders in all phases of the criminal justice system.

Building an International Anti-Drug Consensus. In June 1998, a special session of the United Nations General Assembly underscored the need for international opposition to the illegal drug trade. As a result, the world community adopted the proposal made in the 1998 United States Drug Control Strategy for a ten-year conceptual framework to counter the drug problem and set five and ten-year target dates for reducing supply and demand for illicit drugs.

The political declaration on global drug control adopted during the session represents a forceful, high-level commitment to addressing all elements of the drug problem at both the national and international levels. It emphasized the importance of a balanced approach to reduce drug abuse, eliminate illicit supply, and counter drug trafficking. It also set clear target dates for member states to take action required in specified areas. A target date of 2003 was established for national action to stem the tide of abuse and trafficking in amphetamine-type stimulants, national legislation on money laundering, promotion of judicial cooperation, and implementing demand- reduction strategies. The year 2008 is the target date for achieving significant results in demand reduction; eliminating or reducing illicit drug cultivation; and reducing the manufacture and trafficking in psychotropic substances, including synthetic designer drugs and precursor chemicals.

Promoting International Demand Reduction. The problem of increasing drug abuse is shared by many nations. In the United Kingdom (UK), for example, 48 percent of sixteen to twenty four year-olds questioned in 1996 said they had used illegal drugs in their lifetime, and 18 percent were past-month users. The UK has responded with a comprehensive national drug control strategy. In Mexico, the government is responding to increasing drug abuse by increasing funding for treatment, conducting a "Live Without Drugs" public service campaign, and providing educational programs in schools and on the Internet. In Brazil, cocaine abuse has become more prevalent.

Over the past two years the U.S. has been working closely with the government of Mexico to increase cooperation in reducing the demand for drugs in both countries. In March 1998, the first

U.S.-Mexico Bi-National Demand Reduction Conference was held in El Paso, Texas. More than 300 experts in drug prevention, treatment, and research, as well as government officials, educators and community leaders from both sides of the border attended the conference. Mexico has offered to host a second bi-national conference, scheduled to be held June 23-25, 1999 in Tijuana, Mexico.

Recognizing that no government can reduce drug use and its consequences by itself, the United States encourages and supports private-sector initiatives in drug prevention education. Examples include the *Consejo Publicitario Argentino*, the *Parceria Contra Drogas* in Brazil, and the *Alianza para una Venezuela sin drogas*. The 120,000 U.S. tax-payer dollars that helped establish these national organizations contributed to the generation of more than $120 million in anti-drug media messages in these three countries.

Improved Interagency Coordination. ONDCP chairs an interagency Demand Reduction Working Group, comprised of senior policy officials responsible for administering demand reduction programs at key Federal agencies, whose mission is to promote improved coordination and cooperation among Federal programs, as well as to address policy issues that affect more than one agency. In the past year, subcommittees have worked to develop coordinated policy in such areas as closing the treatment "gap," improving drug treatment in the criminal justice system, and promoting drug-free workplaces in the private sector.

The FY 2000 Federal Drug Control Budget Supports Important Prevention and Treatment Programs

The President's budget for fiscal year 2000 continues and, in key areas, expands important demand reduction programs and initiatives. In total, drug control funding recommended for FY 2000 is **$17.8 billion.** Spending that supports drug education, prevention and treatment programs increases by **$210.0 million** (+3.6%) in FY 2000 over FY 1999 regular appropriations. Major increases in demand reduction programs submitted by the Administration include:

Youth Prevention:

School Coordinators: +$15 million. These additional resources will expand the School Coordinator program, started in FY 1999. With this increase, total funding for this initiative will be $50 million in FY 2000. This program will support the hiring of drug prevention coordinators in nearly half of the middle schools across the country to help improve the quality and effectiveness of drug prevention programs.

National Youth Anti-Drug Media Campaign: +$10 million. This additional funding brings the budget for ONDCP's Media Campaign to $195 million in FY 2000. With this money, ONDCP will continue its targeted, high impact, paid media campaign designed to change naive adolescent perceptions of the dangers and social approval of drugs.

Youth Tobacco Prevention: +$61.0 million. The Centers for Disease Control and Prevention will receive an increase of $27.0 million in drug-related funds to extend state-based efforts to conduct comprehensive programs to reduce and prevent tobacco use. The Food and Drug Administration will receive an additional $34.0 million in drug-related funding in FY 2000 to expand implementation of its final rule intended to halt the supply of tobacco products to children.

Treatment:

Drug Intervention Program: +$100 million. This initiative, funded through the Office of Justice Programs, will provide drug abuse assistance to state and local governments to develop and implement comprehensive systems for drug testing, drug treatment and graduated sanctions for offenders.

Drug Courts: +$10 million. These additional resources will bring total funding for the Drug Courts program to $50 million in FY 2000. This program provides alternatives to incarceration through using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

Treatment Capacity Expansion Grants: +$55 million. This additional funding will help the Substance Abuse and Mental Health Services Administration (SAMHSA) expand the availability of drug treatment in areas of existing or emerging treatment need.

Substance Abuse Block Grant Program: +$30 million ($24.8 million drug-related). This increase for SAMHSA's Substance Abuse Block Grant will provide funding to states for treatment and prevention services. This program is the backbone of federal efforts to reduce the gap between those who are actively seeking substance abuse treatment and the capacity of the public treatment system.

All of us at ONDCP are proud of the growing partnership between the Executive and Legislative branches on drug control issues. The *1999 Strategy* emphasizes the centrality of drug prevention and treatment in the national response to the drug problem. We look forward to working with committee members and, indeed, the entire Congress to ensure that the federal response to the nation's drug problem is comprehensive, appropriately resourced, and completely supportive of states, cities, counties, communities, families, and all citizens who share our commitment to confronting the cancer of drug abuse.

Mr. MICA. Thank you. I understand we have two witnesses who will not be giving opening statements.

So, what we will do now is hear from Dr. Joseph Autry, Deputy Administrator of the Substance Abuse and Mental Health Services Administration.

There will be another buzzer in about 4 minutes. You can go about 2 minutes after that, Dr. Autry. Then we will recess for a vote and come back and hear from the others.

Mr. SCHECTER. Mr. Chairman.

Mr. MICA. Yes.

Mr. SCHECTER. I forgot to mention that I do have a statement for the record I would like submitted.

Mr. MICA. Without objection, that will be made a part of the record.

You are recognized, Dr. Autry.

STATEMENT OF JOSEPH H. AUTRY III, M.D., DEPUTY ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Dr. AUTRY. Let me start by thanking the subcommittee and you, Mr. Chairman, and Congresswoman Mink. We really appreciate this opportunity of coming before you.

I am accompanied today by Dr. Westley Clark, whom you mentioned earlier heads our Substance Abuse Treatment Program; and Dr. Karol Kumpfer, who heads our Substance Abuse Prevention Program.

Although they are not making presentations today, they are available to answer questions. We felt, in the interest of trying to get the fullest possible information to the subcommittee, that it was best to have the people who deal with this on a day-to-day basis with us.

I would like to submit my testimony for the record.

Mr. MICA. Without objection, that will be made a part of the record.

Dr. AUTRY. I also want to apologize that Dr. Nelba Chavez, who is the Administrator, cannot be here today. This is a subcommittee before whom she was very much looking forward to testifying.

She is unfortunately involved in other activities that she can do and I cannot. So, that is why I am here. Let me just say that we concur with what Dan Schecter has said.

Our mission focuses primarily on goals 1 and 3, which are educating America's youth to reject illegal drugs, alcohol, and tobacco, and reduce health and social costs to the public of illegal drug use.

I, like Dan, have been around a long time. We were debating a little bit earlier which one of us had been here the longest. Despite the fact that I am the grayest, I think he actually beats me by a little bit.

I have never seen a drug control strategy or any other major Federal program that has the degree of collaboration, coordination, development, implementation, and insured responsibility.

I think I can say that without exception in all of my years of service here. We are all aware, as you have said in your opening statement, of the devastation of substance abuse; not only on individuals, families, and communities, but how it also dovetails with

other social problems, such as unintended pregnancy, HIV/AIDS, crime, welfare, violence, school dropout, suicide, homelessness, and injuries.

It is clearly one of our most pressing public health problems. We did a recent survey of American adults and found that 56 percent of them listed drugs as the top priority that was facing their American children.

Crime was second at 24 percent. This is a relationship that is well-known to this subcommittee and I will not go into it in my verbal testimony. We also know that prisons and punishment are not sufficient in and of their own right to deal with the problem of substance abuse in this country.

It takes, prevention, intervention, and education to augment those efforts. We concur with this subcommittee that it takes a comprehensive approach that cuts across all of the goals of the strategy in order to make a dent in the substance abuse problems that face our Nation.

I would like to highlight a couple of programs that we fund in SAMHSA to show you how we actually put this kind of information to the test. We have programs that are focused more on a comprehensive, coordinated, community approach that address family, school, and mental health problems that may lead to substance abuse and other destructive behaviors.

We know many times in adolescence that there are mental health problems that develop prior to substance abuse problems. We have the opportunity of intervening early and heading off the substance abuse problems that may develop.

We also know that there are tremendous gaps in our States in terms of both prevention and treatment needs. One of our programs is the State incentive—Grant Program in which we fund 19 States, through the Governor's Office, to provide a comprehensive, integrated approach identifying, and filling gaps, and leveraging resources to address the prevention needs.

We work collaboratively while colleagues at the Department of Education, Department of Justice, Bureau of Prisons, Department of Transportation, Office of National Drug Control Policy, HUD, and others in helping them implement a range of programs.

We have six regional centers that provide technical assistance to a range of programs that cut across the Federal and State programs. You mentioned earlier your concern about the devastation on families.

We have a specific initiative that focuses on strengthening families and teaching better parenting skills; teaching parents how they can help their kids, not only say no, but say no thank you; that is not for me. It interferes with my future that is too bright to have it clouded by the drugs that you are trying to get me to use.

We have also worked with the National Media Campaign. I will just highlight one thing that has happened as a result of the campaign that Dan mentioned. Since this campaign went into effect, we have increased our National Clearinghouse Hotline to a 7-day operation, 24 hours a day.

We have received approximately 2,000 phone calls a day since the media campaign has been implemented. We have distributed over 636,000 copies of Keeping Youth Drug Free, which is a guide

to help parents learn how to talk with their kids. We put a copy of that in your package for your information.

I also want to talk about treatment. Dan mentioned that treatment is effective. That is true. We know that it does a whole variety of things.

There are studies that show that people who have been through treatment can remain drug free or substantially reduce their substance abuse following treatment.

We have people who actually go to work, who pay taxes, who actually decrease crime, who decrease their drug use and become the kinds of citizens that we would all like for them to be.

They reduce their criminal activity and they reduce their risky sexual behavior. We are working with the National Institute on Corrections and the Office of Justice Programs in helping develop treatment and management programs for the dually diagnosed persons in the criminal justice system.

We also have a Targeted Capacity Expansion Program in addition to our Block Grant Program. These are funds that are aimed at specific communities who have emerging drug problems or who have specific emerging needs for treatment services that cannot be met within the Existing Block Grant Funds.

We are also in the process of developing new knowledge and implementing knowledge on effective prevention and treatment interventions; working with our States, mayors, town and county officials, the Congressional Black Caucus, and Indian Tribal Governments.

We have also mounted a recent major initiative on HIV/AIDS. Let me close with two things. One is, you asked about how accountable are we?

Every program that we implement requires not only that evaluation of the program for the specific grantees, but also for the overall program as a whole. We have GPRA measures that cut across our entire agency, as well as specific program measures.

We have recently expanded our household survey that will be sampling about 70,000 households a year, including 25,000 kids between the ages of 12 and 17. For the first time, this will allow us to make State-level estimates of the drug use in this country, so we can better pinpoint the distribution of our resources and the kinds of treatment and prevention programs that we need to put on the ground.

Last, you asked are we going to be able to meet the goals that we have set out for the Strategy? I think, quite honestly, given the kind of cooperation and teamwork that we have across the Federal Government with our colleagues in the regions, the States, and the communities the answer to that question is yes.

Thank you.

[The prepared statement of Dr. Autry follows:]

TESTIMONY

JOSEPH AUTRY, M.D.

ACTING DEPUTY ADMINISTRATOR

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HOUSE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE

MARCH 18, 1999

WASHINGTON, D.C.

Mr. Chairman and Members of the Subcommittee. On behalf of the Administrator of the

Substance Abuse and Mental Health Services Administration (SAMHSA) I want to thank you for the opportunity to testify this afternoon. Your interest in drug control policy and your commitment to bipartisan support of a comprehensive response to the Nation's drug abuse problem are much appreciated. I am accompanied today by Dr. Westley Clark, Director of SAMHSA's Center for Substance Abuse Treatment (CSAT) and Dr. Karol Kumpfer, Director of SAMHSA's Center for Substance Abuse Prevention (CSAP). Both are available to address questions you may have later in the hearing.

I am pleased to present to you today the role and responsibilities of SAMHSA in achieving the goals and objectives of the President's National Drug Control Strategy. As you know the strategy provides the Nation a long-term, balanced approach that focuses on prevention, treatment, research, law enforcement, protection of our borders, international cooperation and policy development. As the Federal Government's lead agency for improving the quality and availability of substance abuse prevention and addiction treatment services, SAMHSA's mission directly supports Goal 1 - "Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco" and Goal 3 - "Reduce health and social costs to the public of illegal drug use" of the strategy. Within these two goals, SAMHSA supports a number of programs, many in partnership with other Federal agencies, including the Office of National Drug Control Policy, Department of Education, Department of Justice and the Department of Transportation and private sector organizations. All are targeted towards achieving objectives detailed under the respective goal of the strategy.

The importance of our work in substance abuse prevention, addiction treatment and mental health services cannot be overstated. Drug and alcohol abuse ravage the lives of millions and fuel crime, domestic violence, disease and premature death. When the link is made between substance abuse and other headline grabbing problems -- unintended pregnancy, HIV/AIDS, crime, welfare, violence, school drop-out, suicide, homelessness, and injuries, substance abuse is

clearly one of our most costly public health problems.

As with any other public health problem, we must achieve public health solutions. Study after study has shown, drugs are dominating the public's concern about the future of children in this country. A survey of American adults found 56 percent listed drugs as the top problem facing American children. Crime was second, at 24 percent.

The relationship between crime and drugs and the cost of drugs and crime to our country is clear. More than 1.7 million people are behind bars in America at an annual cost to the taxpayer of $38 billion. Seventy percent or 1.2 million of them have histories of drug and alcohol abuse and addiction. For hundreds of thousands of these individuals drug abuse and addiction is the core problem that prompted their criminal activity. Our prison and punishment approach to substance abuse is not sufficient by itself. Instead we need to approach drug abuse as a public health issue and invest our resources in reaching adults, adolescents, and children in need of substance abuse prevention and treatment services before they reach the criminal justice system.

In the area of prevention - Goal 1 of the Strategy - our investments seems to be paying off. Each year we release SAMHSA's National Household Survey on Drug Use. While we are cautiously optimistic that the recent increase in drug use maybe leveling off among youth, we are concerned that our young people continue to use drugs and drink alcohol at an unacceptable rate. To ensure our programs are keeping up with current issues and trends, over the past three years at SAMHSA we have re-engineered our programs, widened our circle of partners and adopted a long term public health approach. With this shift in strategy we have redirected our efforts from narrowly focused drug prevention efforts to a more comprehensive coordinated community approach that identifies and addresses family, school, and mental health problems that may lead to substance abuse and other destructive behaviors.

For example our new State Incentive Grant Program offers technical and financial support to Governors in 19 states to help them deliver research-based substance abuse prevention services. A full 85 percent of these funds are being directed to community prevention programs, resulting in the funding of approximately 500 community based programs in the 19 States. The "incentive" nature of the State Incentive Grants, encourages Governors to mobilize and coordinate state-wide efforts in preventing drug use among youth. In developing this program, we asked Governors to take a fresh look at all the funding streams focused on preventing substance abuse in their state and identify the needs and gaps. Then we asked for innovative plans that leverage resources to reach youth, parents and families in their homes, schools, and workplaces with proven substance abuse strategies. In addition to adapting effective prevention models to local situations and their needs the State Incentive Grant program requires states to account for, coordinate, and strategically manage all substance abuse prevention funding streams in the state, including the 20 percent prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant, Safe and Drug Free Schools and Communities Programs and other Federal programs.

I'm pleased that we've been able to award grants to states with the best proposals and to work with them to help move their programs forward through the establishment of 6 Regional Centers for the Application of Prevention Technology. The Regional Centers are focusing their efforts on the application of National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA) and SAMHSA proven and promising research-based substance abuse prevention practices, methods, and policies in the states that receive incentive grants. These regional centers are critically important. They will identify and reach out to practitioners and programs to ensure they are using the latest science based prevention knowledge available to reduce substance abuse at the community and individual level.

To continue to improve services that are available to very young children, SAMHSA has

initiated the Starting Early-Starting Smart collaborative effort. I say collaborative because SAMHSA is collaborating with The Casey Family Program, the Department of Education and other HHS operating divisions to develop new knowledge, demonstrate what works, and create collaborative community-based partnerships that will sustain improved health and health care services for children from birth to age 7 and their families or caregivers. SAMHSA initiated the Starting Early-Starting Smart program because so many social and economic factors impact children's mental health and their potential for substance abuse. This interagency collaboration will bring all the available resources to bear on providing coordinated, quality services for children and their caregivers. I clearly see this collaboration as just the beginning of a much needed effort to improve the lives of children and, ultimately, as our first line of defense in preventing drug use.

Research has shown that with co-occurring mental and addictive disorders, the mental disorder often occurs first, during adolescence and 5 to 10 years before the addictive disorder. While this provides a "window of opportunity" for targeted substance abuse prevention interventions and needed mental health services, two-thirds of young people in this country who suffer from a mental disorder are not receiving the help they need. Without that help these problems can lead, in addition to alcohol and illicit drug abuse, to school failure, family discord, violence and even suicide. SAMHSA is leading a vigorous effort to help families, educators, and others who work with children and adolescents, as well as young people themselves - to recognize mental health problems and seek appropriate services. This is a key goal of our Children's Mental Health Services Program and our Caring for Every Child's Mental Health: Communities Together initiative.

We are also very pleased with the initial response to the National Youth Anti-Drug Media Campaign. While the corporate "in kind" contributions of free public service announcements have exceeded expectations and the goal for reaching target audience members continues to be

surpassed, the first measures of impact are coming from SAMHSA. The national phone number used to obtain more information is SAMHSA's National Clearinghouse for Drug and Alcohol Information. In cooperation with the Office of National Drug Control Policy (ONDCP), we have expanded our hours of operation to 7 days a week, 24 hours a day. We are receiving about 2000 calls a day as a result of the media campaign. Approximately half are parents looking for ways to start a conversation about drugs with children in their care. Since the campaign started to run nationally last July, SAMHSA has distributed over 600,000 copies of the publication "Keeping Youth Drug Free" which includes suggested conversations for parents and other caregivers to increase their confidence and knowledge.

SAMHSA's Center for Substance Abuse Prevention (CSAP) is also working with other federal agencies on a number of targeted areas, including underage drinking, family-focused prevention programs, and children of substance-abusing parents to improve system performance and service quality. For example, CSAP and NIAAA have a study underway to examine the effects of alcohol advertising on underage drinking. We are also working with NIAAA to identify, test and develop effective interventions to prevent and reduce alcohol-related problems, including death, among college students.

When it comes to our families, there are many effective strategies for preventing substance abuse among children in the home. Our efforts at SAMHSA are focusing on improved implementation of appropriate family strengthening substance abuse prevention strategies. Also of great concern are the 8.3 million American children who live with at least one parent who is alcoholic or using drugs and in need of substance abuse treatment. These children face a significantly higher-than-average risk for early substance abuse, addiction and the development of a variety of physical and mental health problems. To address this high risk population, CSAP is developing prevention interventions specifically designed for these children and families as

part of an interagency Strengthening Families Initiative.

In the area of alcohol and drug treatment - Goal 3 of the Strategy - SAMHSA has repeatedly demonstrated the effectiveness of Federally supported programs. For example, an evaluation of treatment programs funded by the Center for Substance Abuse Treatment (CSAT) found a 50 percent reduction in drug use among their clients one year after treatment. Additional outcomes include improved job prospects, increased incomes, and better physical and mental health. Clients are less likely after treatment to be homeless and less likely to be involved in criminal activity and risky sexual behaviors. Our Services Research Outcomes Study, released in September 1998, produced similar findings. This national sample of substance abuse treatment programs showed that participating individuals sustained reductions in substance abuse for at least five years following treatment. Similar findings have been produced by NIDA and in the States of California, Oregon and Minnesota and by RAND corporation. We have achieved successful results that parallel or exceed the results of patients receiving treatment for other chronic illnesses like diabetes, hypertension and asthma. Yet, we are living in an America where substance abuse treatment is stigmatized and private insurance coverage for treatment is not equal to coverage for treatment of other medical conditions. According to the National Household Survey on Drug Abuse (NHSDA) 63 percent of people with a severe drug problem — about 3.6 million people in need of treatment — did not receive the care they needed in 1997. With the Congress's leadership we can help others understand that drug abuse is a serious public health issues that must be addressed and can be addressed successfully.

To help support and maintain State substance abuse treatment and prevention services, SAMHSA is providing $1.6 billion in funds through the Substance Abuse Prevention and Treatment Block Grant in FY 1999. While block grant investments that support and maintain state systems are vital, they represent only one part of the comprehensive approach needed to improve access to quality substance abuse prevention and addiction treatment services in the

U.S. To increase access and reduce waiting times for services, Federal investments in targeted capacity expansion and development and application of new more effective and efficient interventions are essential to improve system performance and service quality as well as cultivate a system that is responsive to current and emerging needs. These investments help to connect the laboratory research funded by the National Institutes for Health and others to the needs of our citizens through the delivery of everyday health care services. Without the bridge that SAMHSA provides, the benefits from Federal investments in bench science and biomedical research will not reach our citizens or achieve full potential.

Wise investments in improving performance and quality of services through SAMHSA's Knowledge Development and Application (KD&A) grant program stimulate the discovery of new and more cost effective ways to deliver services paid for through block grant funding, Medicaid, Medicare and private sector insurance. For example, CSAT has launched an initiative to determine the effectiveness of available methamphetamine addiction treatments for various populations and the cost effectiveness of the various treatment approaches. CSAT is also investing in improving treatment services available for adolescents and adults dependent on marijuana. Additionally, CSAT has also initiated a program to identify currently existing and potentially exemplary adolescent treatment models and to produce short-term evaluation of outcome measures and cost-effectiveness of such models with a special emphasis on models that focus on treatment for adolescent heroin abusers. Because the effectiveness of current treatment models for adolescents is still being developed, CSAT is working with NIAAA to identify effective treatment interventions for adolescents who abuse alcohol and those who have become alcoholics. CSAT is also working with the Department of Justice to support the Drug Court Program and through this effort we are piloting three ***Family Drug Courts*** projects in which alcohol and other drug treatment, combined with intervention and support services for child and family, are integrated with the legal processing of the family's case. And, SAMHSA is working with the Food and Drug Administration and the National Institutes of Health to increase access to

and improve the quality and accountability of methadone and levo-alpha-acetyl-methadol (LAAM) treatment for people with heroin addiction. Improving access and quality of treatment will be accomplished by moving from the current regulatory environment to a system that will combine program accreditation with statutory requirements.

While the drug problem is national in scope, our data provides us the ability to gauge the regional nature of emerging trends. In addition, mayors, town and county officials, the Congressional Black and Hispanic Caucuses and Indian Tribal Governments experiencing the effects of drug use in their communities have appreciated Federal leadership in helping them address emerging drug trends and the related public health problems, including HIV/AIDS. SAMHSA's Targeted Treatment Capacity Expansion program is key to these efforts. These grants, already in 41 communities, are providing rapid and strategic responses to the demand for services that are more regional or local in nature. For example, the outbreak of methamphetamine use that has spread across the Southwest or dramatic heroin use increases reported in localized areas can be more rapidly addressed as a result of this program.

Finally, we are continuing to provide information to the President, the Congress and the American people on the performance of treatment and prevention programs. SAMHSA's Government Performance and Results Act (GPRA) plan is linked to ONDCP "Performance Measures of Effectiveness," which are derived from the goals and objectives of the National Drug Control Strategy. We are also making a significant investment in data collection by expanding the National Household Survey on Drug Abuse. The expanded survey, which is already underway, will provide enhanced national estimates of substance abuse and, for the first time, comparable state-level estimates of substance abuse. The analysis of trends over time from the expanded Household Survey in combination with other data sources will provide an invaluable tool for reporting to Congress; directing future investments, especially through the Substance Abuse Prevention and Treatment Block Grant; and for measuring outcomes for the

National Drug Control Strategy.

Improving accountability for Substance Abuse Prevention and Treatment Block Grant funds is a priority for SAMHSA. Through reauthorization we are proposing to transition our block grants into Performance Partnerships. Our proposal increases state flexibility by allowing states to set their own priorities for expenditures and management of block grant funds and at the same time holding them accountable for achieving capacity, process and outcomes measures agreed upon through negotiations.

Mr. Chairman, we are confident the long-term National Drug Control Strategy will meet its goals through continued collaboration of Federal agencies and the support of the Congress. I assure you SAMHSA will continue to be a vital partner in achieving Goal 1 and Goal 3 that will bring about a 50 percent reduction in drug use and availability and reduce the health and social costs associated with drug abuse by 25 percent by 2007. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear today. We will be pleased to answer any questions you may have.

Mr. MICA. Thank you for your testimony.

We are going to recess the subcommittee at this time. We will reassemble here in about 15 minutes.

Thank you.

[Recess.]

Mr. MICA. The subcommittee will come to order.

We have heard from Daniel Schecter and from Joseph Autry. We will now hear from Richard Millstein, Deputy Director from the National Institute on Drug Abuse, the National Institutes of Health.

You are recognized, sir. Did you have a lengthy statement for the record?

STATEMENT OF RICHARD A. MILLSTEIN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH

Mr. MILLSTEIN. I do have a formal statement for the record that I would like to be entered.

Mr. MICA. Without objection, that will be made a part of the record.

Mr. MILLSTEIN. Thank you.

Mr. MICA. You are recognized, sir.

Mr. MILLSTEIN. Mr. Chairman and members of the subcommittee, I am pleased to share with you what science has shown about drug abuse, its prevention, and treatment, and how we can use this research information to educate the public and practitioners about this complex problem, through research that the National Institute on Drug Abuse [NITA], supports and conducts.

We now know that drug abuse is a preventable behavior and that drug addiction is a treatable disease. We have learned that although initial drug use is a voluntary and therefore preventable behavior; drug addiction is a chronic illness and is characterized for many people by occasional relapse. At its core, the state of addiction comes about because prolonged drug use has modified the brain's functioning in ways that last long after the individual stops using drugs. These brain changes essentially are what make addiction and brain disease.

The good news is that addiction is treatable, though it is never a simple disease to treat. As addiction affects all aspects of a person's life.

An individual's treatment program must address not only the individual's current drug use, but help with the maintenance of a drug free lifestyle through a sure projected function in the family, at work, and in society.

Fortunately, just as with other illnesses, drug abuse professionals have at their disposal an array of tools to treat addicted individuals. Among these are medications and promising science-based behavioral therapies, proven to be efficacious in some settings, but not yet tested on a large scale or in diverse patient populations. That is why we are launching the National Drug Abuse Clinical Trials Network.

The Network will form partnerships between university-based medical and research centers and community-based treatment providers to test and deliver a wide array of treatments and real life

settings, while simultaneously determining the conditions under which the treatments are most successfully adapted.

The Network will also serve to transfer knowledge into the community setting. In addition, with research and practitioner organizations, and our Federal colleagues, including those on this panel, we will disseminate the research findings. Thus, moving science-based treatment into practice.

The other encouraging news is that drug addiction treatment can be very effective. In fact, surprisingly, it works just as well as medical treatments for other chronic illnesses like asthma, hypertension, and diabetes that also have major medications and behavioral compliance issues.

Treatment effectiveness has been confirmed by a number of studies, including one sample of 10,000 patients in terms of decreased drug use, reduced involvement in illicit acts, and preventing the spread of HIV and Hepatitis C.

As with all medical conditions, science will lead the way as we develop more effective approaches to treat addiction. Science already has shown that there is one common area—in the brain where all drugs that are abused act.

This seems to hold true for heroin, cocaine, nicotine, marijuana, and one of our country's most serious emerging drug problems, methamphetamine. We have mounted a major science-based initiative focusing on methamphetamine public education and prevention campaigns, and the development of more effective behavioral treatments, and new medications to treat methamphetamine addiction and overdose.

We have developed and disseminated widely a Community Drug Alert Bulletin on methamphetamine. Ultimately, we know that our best treatment is prevention. We also know that we must provide the public with the necessary tools to play an active role in preventing drug use in their own local communities.

This is likely one of the reasons why NIDA is preventing drug use among children and adolescents. The red book that Dan Schecter showed you has become one of our most requested publications since its release last year, with over 200,000 copies distributed.

We also continue to support town meetings across the Nation to disseminate our research findings and to educate the American public about what science is teaching us about addiction.

We also have a strong science education program to ensure that our Nation's youth have accurate science-based information to make healthy lifestyle choices. For those who have access to the Internet, we have placed many of our materials on NIDA's Home Page, which last month received 23,600 page hits a day.

We have also set-up a Fax-on-Demand Service called NIDA Info-Fax which provides fact sheets on drugs and abuse that can be faxed, mailed, or read over the phone to a requester. Since we debuted this system in December 1997, we have distributed more than 250,000 fact sheets.

Because addiction is such a complex and pervasive health issue, research is a part of a comprehensive public health approach. It also includes education and prevention, and treatment and after

care service. These are all areas addressed by the concerted Government effort to reduce drug use in this country, as outlined in the National Drug Control Strategy.

Thank you for the opportunity to testify at this hearing.

[The prepared statement of Mr. Millstein follows:]

Hearing before the
Subcommittee on Criminal Justice,
Drug Policy and Human Resources
House Government Reform and Oversight Committee

"Oversight of Agency Efforts to Prevent and Treat Drug Abuse"

Richard A. Millstein
Deputy Director
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

March 18, 1999
Room 2247
Rayburn House Office building

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Statement by
Richard A. Millstein
Deputy Director, National Institute on Drug Abuse

Mr. Chairman and Members of the Subcommittee, I am pleased to be part of this distinguished panel to share with you what science has come to show about drug abuse, its prevention, and its treatment. I would like to start by stating that all of the research activities that I will discuss today are in fact part of a concerted government effort to reduce drug use in this country that is outlined in the Office of National Drug Control Policy's National Drug Control Strategy.

In large part because of the research that the National Institute on Drug Abuse (NIDA) supports and conducts, we now know that drug abuse is a preventable behavior and that drug addiction is in fact a treatable disease. Research has come to define addiction, though it originates as a voluntary behavior, as a chronic, and for many people reoccurring disease characterized by compulsive drug seeking and use that results from the prolonged effects of drugs on the brain. A variety of studies in both humans and animals have demonstrated that chronic drug use does in fact change the brain in fundamental ways that persist long after the individual has stopped taking the drug. Of course, this change from abuse to addiction occurs at different times for different people, and is dependent upon a variety of genetic and environmental factors. By using advanced brain imaging technologies we literally are able to see that the addicted brain is different from the non-addicted brain. These brain changes are essentially what makes addiction a brain disease.

The good news is that addiction is in fact treatable, though it is never a simple disease to treat. One of the overarching goals of treatment is to reverse or compensate for these brain changes. Another treatment goal is to return the individual back to a functioning member of society. Similar to the way addiction affects all aspects of a person=s life, his or her treatment program must address the "whole person." It must address not only the individual=s drug use, but also provide him or her with the tools necessary for maintaining a drug-free lifestyle, while also helping with the achievement of productive functioning in the family, at work, and in society. Because addiction is so complex, and can impact so many aspects of the patient' s life, effective treatment programs typically must incorporate many components, with each directed to a particular aspect of the illness and its consequences.

Fortunately, just as with other illnesses, drug abuse professionals have at their disposal an array of quite useful tools to treat addicted individuals, although admittedly not enough. NIDA-supported research, for example, has helped to bring to the world LAAM (levo-alpha-acetyl-methadol) and methadone, the most effective medications to date for heroin addiction; and we have standardized notable behavioral interventions, such as cognitive behavioral therapies and contingency management, that are effective in treating both adults and adolescents. We are also working to bring new medications for cocaine addiction to the Nation=s forefront. In fact, NIDA' s medications development program is taking the first promising anti-cocaine medication into multisite Phase III Clinical trials. These trials will evaluate two innovative routes of administration for the medication selegiline, in the form of a transdermal patch and as a time released pill, to determine which is most beneficial to the populations being studied.

This trial will also include a behavioral component, since treatment researchers are finding that although behavioral and pharmacological treatment approaches can be extremely useful when employed alone, integrating both treatments, in ways specific to an individual=s needs, is likely the best way to treat addictive disorders. This is the kind of information that needs to be disseminated and translated in a way that is both useful and used by busy treatment providers. We realize that just supporting research is not enough. NIDA is also committed to working with the drug abuse professional community to actively transfer research knowledge in a proactive way into the community setting. To do this, NIDA works with a large number of constituent organizations and our federal colleagues, such as those in the Substance Abuse and Mental Health Services Administration and at the Office of National Drug Control Policy, to help disseminate research findings.

One of the major ways that we are planning to disseminate important treatment information is by launching our National Drug Abuse Treatment Clinical Trials Network. As is the case for other chronic disorders, effective treatments for addiction exist. However, the efficacy of these new treatments has been demonstrated primarily in specialized treatment research settings, with somewhat restricted patient populations. As a consequence, few of these new treatments are being applied on a wide-scale basis in real life practice. In response, NIDA is establishing this Clinical Trials Network which will serve as both the infrastructure for testing science-based treatments in diverse patient and treatment settings, and the mechanism for promoting the rapid translation of new science-based treatment components into practice. We already have quite a number of efficacious behavioral and pharmacological therapies ready to be tested including new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and new,

manualized approaches to individual and group drug counseling. Medications to be studied include naltrexone and buprenorphine for heroin addiction, and those currently being developed by NIDA for cocaine. We are also optimistic that this Network will allow us to form successful partnerships between university-based medical and research centers and community-based treatment providers to test and deliver a wide array of treatments, while simultaneously determining the conditions under which the novel treatments are most successfully adopted. Demonstrating effectiveness will foster the incorporation of new interventions into ongoing community-based drug treatment, thereby improving treatment throughout the country.

The other encouraging news in the treatment arena is that research shows that drug treatments are as, or more, effective than treatments for other chronic, often reoccurring, disorders with major medications and behavioral compliance issues, such as diabetes, hypertension, and asthma. NIDA's own exhaustive study on the effectiveness of treatment, the Drug Abuse Treatment Outcomes Study (DATOS), which tracked a sample of over 10,000 drug abusers in nearly 100 treatment programs in 11 cities across the Nation for three years, overwhelmingly confirmed the effectiveness of drug abuse treatment. Among the patients that DATOS studied, drug use in the year after treatment was significantly lower than in the year prior to treatment. This was true for all four types of treatment studied: outpatient methadone, outpatient drug-free, long-term residential, and short-term inpatient. Treatment also led to significant improvements in other aspects of patients' lives, such as reduced involvement in illegal acts. It is also important to note that DATOS findings are corroborated by urinalysis testing.

An abundance of other studies also confirm the effectiveness of treatment. Several conclude that drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment, whether measured by self report or by urinalysis and records review. Treatment also has been shown to be highly effective in preventing the spread of HIV. Not only do individuals who enter drug abuse treatment programs reduce their drug use, but this in turn has been found to lead to fewer instances of other high-risk behaviors as well. For example, in a longitudinal study of injection drug users, over 20% of those **not** in treatment had become seropositive after 18 months, compared to less than 5% of those receiving methadone maintenance treatment. NIDA-funded scientists have also demonstrated that comprehensive treatment of drug-addicted prison inmates, when coupled with treatment after release from prison, reduces almost by 70% the probability of their being rearrested and the likelihood they will return to drug use.

In short, research has established that drug treatment reduces crime, reduces the spread of infectious diseases such as AIDS and hepatitis C, and restores the ability of addicted individuals to be functioning contributing members of society.

As with all medical conditions, it is science that will lead the way as we look to develop even more effective approaches to treat addiction. In fact it was a series of basic scientific discoveries that pointed us to one common reward pathway in the brain where all drugs of abuse act. The data now suggest that, independent of a drug=s initial site of action, every drug--be it nicotine, heroin, cocaine, marijuana or amphetamine--appears to increase the levels of the neurotransmitter dopamine in the brain pathways that control pleasure. We have come to believe that the ability to increase brain dopamine levels is a common characteristic of most drugs of abuse, although we are

simultaneously exploring other neurochemical systems and neurocircuits hat might be involved in the addiction process.

Understanding these neurotransmitter systems and brain circuits is central to understanding one of the country's most alarming emerging drug problems, methamphetamine abuse. The use of this highly addictive drug, once dominant primarily in Hawaii and the Southwest, is spreading rapidly across the country. Just a decade ago methamphetamine was confined to relatively limited pockets of use in the West. It has now reached crisis proportions in Western and mid-Western parts of this country. This is of particular concern because of recent research demonstrating the neurotoxic effects of the drug. NIDA has made methamphetamine research a high priority area. We have expanded our research portfolio to develop effective medications to treat the addiction, as well as to develop new tools such as anti-methamphetamine antibodies to be used by emergency room physicians to treat the growing number of overdoses. We are confident that we can develop effective medications for this dangerous drug, as well as effective prevention approaches tailored to the populations known to use this drug.

Ultimately we know that our best treatment is prevention. We also know that we must provide the public with the necessary tools to play an active role in preventing drug use in their own local communities. This is likely one of the reasons that NIDA's "Preventing Drug Use Among Children and Adolescents," has become one of our most popular publications since we debuted it last year. This user-friendly guide of principles summarizes knowledge gleaned from over 20 years of prevention research. Over 200,000 copies have been circulated to communities throughout the

country as they evaluate existing prevention programs and develop new ones. The prevention booklet is just one example of how we are using research to reduce drug use.

NIDA is also entering what many would consider the next generation of drug prevention research -- that is, taking the fundamental principles of effective drug abuse prevention programming to the next level so that they are effectively integrated into every community and social system in the country. To accomplish this, we are supporting research that allows us to have a better understanding of what makes people more susceptible to a potential drug problem, and to learn how they progress from their first drug exposure to developing an addiction. Researchers are also working to identify protective factors, those behaviors, environments, and activities that seem to enable many people to avoid drug use altogether, or, for those seeking treatment, to get right back on track if they falter or relapse. All of these prevention activities reflect our commitment to have prevention interventions directed at the specific needs of different groups of youths at risk for drug abuse, including members of different ethnic groups and those living in different socioeconomic situations.

In short, we are interested in providing the broadest audiences possible with the tools necessary to reduce the Nation's overall drug use. Thus, in addition to our research to prevent and treat drug abuse and addiction, NIDA is also concerned about education on these topics. That is why we continue to support Town Meetings across the Nation to disseminate our research findings and to educate the public about what the science is teaching us about addiction. In fact, one of our first Town Meetings was in San Francisco, an area particularly hard hit by methamphetamine, followed by a more recent meeting in Des Moines, another area being severely affected by methamphetamine.

Our next Town Meeting, scheduled for May in Atlanta, will focus on the topic of treatment. In addition to going to the home towns of those in need of research information on drugs of abuse, NIDA has an active information dissemination program that develops and disseminates materials on a continuous basis. Publications such as NIDA's Research Report Series and our Community Drug Alert Bulletin on Methamphetamine present the latest information on drugs of abuse in a concise manner that is understandable to members of the general public. We also have a strong science education program to ensure that our Nation's youth have accurate science-based information to make healthy lifestyle choices. For example, we have developed award winning materials such as our "Mind Over Matter" series that was sent to every middle school in the Nation. "Mind Over Matter" is a series of drug education brochures for students in grades five through nine to spark their curiosity and to inform them with scientific research findings on the brain effects of drug abuse. Educating the public about drug abuse and addiction will continue to be a high priority for NIDA.

Because addiction is such a complex and pervasive health issue, we must include in our overall strategies a comprehensive public health approach, one that includes extensive education and prevention efforts, adequate treatment and aftercare services, and research. Unfortunately, a "great disconnect" still exists between the public's perception of drug abuse and addiction and the scientific facts, though we are committed to eliminating this gap and ensuring that ideology is replaced with science.

Although scientific advances have brought us a long way in our understanding of and approaches to drug abuse and addiction, we still have a lengthy journey ahead in finding solutions to this complex problem. There will be no magic bullet that is going to make drug abuse and addiction go away, but

there is great cause for optimism that science will provide us with the tools necessary to solve this complex and compelling issue that affects us all.

Thank you for the opportunity to testify at this hearing.

Mr. MICA. Thank you for your testimony.

I am pleased to recognize Vicki Verdeyen, Psychology Services Programs, Federal Bureau of Prisons, U.S. Department of Justice.

Welcome and you are recognized.

STATEMENT OF VICKI VERDEYEN, PSYCHOLOGY SERVICES PROGRAMS, FEDERAL BUREAU OF PRISONS, U.S. DEPARTMENT OF JUSTICE

Ms. VERDEYEN. Thank you, Mr. Chairman and members of this subcommittee. I appreciate the opportunity to go over the Bureau of Prisons Drug Abuse Treatment Programs with you today.

Since 1990, every inmate who has been committed to the Bureau of Prisons, their record has been reviewed to determine whether or not their instant offense involved drug or alcohol, whether or not the Judge recommended that they have treatment while they are incarcerated, and whether or not they are being re-committed for a violation involving drugs or alcohol.

The folks who meet any of these elements or criteria are moved into our drug education course, which is a 40-hour course that provides them information about the psychological, social, and physical affects of drug abuse.

We provide that program in all of our institutions. In fiscal year 1998, a little bit over 12,000 inmates went through that course. Since its inception in 1990, over 98,000 inmates have gone through our drug education course.

Additionally, for inmates who have diagnosable substance abuse problems, we provide at 42 of our institutions a Residential Treatment Program. These programs are 6 to 12 months in length.

There is a minimum of 500 hours of treatment provided. During this time, the treatment components really try to target inmates' criminal thinking patterns so that we are working toward reducing any future criminal activity, as well as reducing any tendency to use drugs again.

In fiscal year 1998, we treated a little bit over 10,000 inmates in our Residential Programs. We also offer in all institutions what we call Non-Residential Treatment Programs for inmates who may not otherwise be eligible for the Residential Programs.

These counseling services are coordinated through the Psychology Services Department at the institution. When an inmate completes our program and is being ready to be released back to the community, either through a half-way house, community corrections center, or back to supervision under U.S. probation, we provide that entity with a treatment plan and treatment summary prior to their release so that they can arrange treatment and support services to ease the transition of the inmate back to the community.

Since the inception of our programs, we have been working with NIDA to evaluate their overall effectiveness. We did get some good news last year. In February 1998, we published the first interim report that indicated for inmates who complete our Residential Programs, and for the first 6 months they are in the community, they were 73 percent less likely to be re-arrested, and 44 percent less likely to relapse into drug use.

Additional analysis of this same data has shown us that inmates who go through our treatment programs, while they remain in the institution, also engage in significantly less misconduct. So, this helps us ensure safe, secure institutions as well.

This concludes my formal statement. I will be happy to answer any questions you or other members of this subcommittee may have.

[The prepared statement of Ms. Verdeyen follows:]

Written Statement of
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Before The
Subcommittee on Criminal Justice, Drug Policy, and Human Resources

Of The
House Committee on Government Reform

March 18, 1999

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to appear before you today to provide information regarding drug abuse treatment programs in the Federal Bureau of Prisons.

The Federal Bureau of Prisons has provided drug treatment in various forms for decades. Since the passage of the Anti-Drug Abuse Acts of 1986 and 1988, both of which included an increased emphasis on and resources for drug treatment, the Bureau has redesigned its treatment programs. With the help of the National Institute on Drug Abuse (NIDA), in support of the National Drug Control Strategy, and after careful review of drug treatment programs around the country, the Bureau has developed a drug treatment strategy that incorporates the "proven effective" elements found through this review. The Bureau's strategy addresses inmate drug abuse by attempting to identify, confront, and alter the attitudes, values, and thinking patterns that lead to criminal and drug-using behavior. The current program includes an essential transitional component that keeps inmates engaged in treatment as they return to their home communities.

abuse treatment programs. In an effort to identify the population with drug abuse treatment needs, the Bureau initiated a Substance Abuse Needs Assessment in the summer of 1991. During this 3-month period, every inmate entering the Bureau completed the Inventory of Substance Use Patterns. Of the inmates completing this inventory, 30.5 percent met the criteria for drug dependence as listed in the American Psychiatric Association's Diagnostic and Statistical Manual, Third Edition, Revised. The Bureau developed and expanded its drug abuse treatment programs based on this 30.5-percent figure. In FY 1999, the Bureau will review this figure using recent data collected from our institutions.

DRUG ABUSE PROGRAM DESCRIPTIONS: ELIGIBILITY AND CONTENT

DRUG ABUSE EDUCATION

Program Screening. Upon entry into a Bureau facility, an inmate's records are assessed to determine whether: 1) there is evidence in the Presentence Investigation that alcohol or other drug use contributed to the commission of the instant offense; 2) the inmate received a judicial recommendation to participate in a drug treatment program; or 3) the inmate violated his or her community supervision as a result of alcohol or other drug use.

If an inmate's record reveals any of these elements, the inmate is required to participate in a Drug Abuse Education course, available in every Bureau institution.

In addition, as part of the standard initial psychological screening, inmates are interviewed concerning their past drug use to determine their need for drug treatment.

Program Content. Participants in Drug Abuse Education receive information on alcohol and drugs and the physical, social, and psychological impact of these substances. Participants must complete an assessment of their lives, including the costs their drug use has had on their health, on the lives of their family, and on the community.

Inmates who undergo drug abuse education are introduced to the other components of the Bureau's drug abuse treatment program. Those inmates who are identified as having a further treatment need are strongly encouraged to volunteer for the Bureau's Residential Drug Abuse Treatment Program.

In FY 1998, the Bureau disseminated a revised Drug Abuse Education curriculum, updating the data and treatment information presented. The new curriculum places an even stronger emphasis on encouraging inmates with substance abuse disorders to enter the Bureau's Residential Drug Abuse Treatment Program.

In Fiscal Year 1998, 12,002 inmates participated in the Drug Abuse Education course. This figure decreased slightly from FY 1997 due to the large number of inmates at minimum security level facilities who entered Residential Drug Abuse Treatment program instead. Drug Abuse Education is waived for inmates who participate in the Residential Drug Abuse Treatment Program.

RESIDENTIAL DRUG ABUSE TREATMENT PROGRAMS

Program Overview. Currently, 42 Bureau of Prisons institutions operate residential drug treatment programs, with a combined annual capacity of over 6,000 participants (see Attachment I for program locations). It is called a residential program because the inmates who participate in it are housed together in a separate unit of the prison that is reserved for drug treatment programs. The programs are 6, 9, or 12 months long and provide a minimum of 500 hours of drug abuse treatment. The Bureau has a three-phase treatment curriculum that is followed in every Residential Drug Abuse Treatment Program.

The 6-month residential programs provide intensive treatment, 5-6 hours a day, 5 days a week. In the 9 and 12-month programs, treatment is provided for at least 3-4 hours a day, 5 days a week. The remainder of each day is spent in education, work skills training, recreation, and other inmate programs. Each Residential Drug Abuse Treatment Program is staffed by a doctoral-level psychologist who supervises treatment staff, each of whom carries a caseload of no more than 24 inmates.

Program Eligibility. Prior to acceptance into a residential drug treatment program, inmates are interviewed to determine whether they meet the diagnostic criteria for an alcohol or illegal/illicit drug use disorder as defined by the American Psychiatric Association, Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). An inmate is eligible for a Residential Drug Abuse Treatment Program if he or she:

(1) has a DSM IV diagnosis for alcohol or illegal/illicit drug abuse or dependence disorder and a record review supports this diagnosis;

(2) has no serious mental impairment that would substantially interfere with or preclude full program participation;

(3) signs the Agreement to Participate in the Bureau's Drug Abuse Programs; and

(4) is, ordinarily, within 36 months of release.

Virtually all Federal inmates who are eligible for residential drug abuse treatment are provided the opportunity to participate in the residential program. Residential treatment typically is provided close to the prisoner's release to the community to ensure continuity with the transitional treatment program, in which the offender is required to participate as they enter supervision in the community.

Program Content. The strategies used in the Bureau of Prisons' Drug Abuse Treatment Program place responsibility for change on the individual by demanding compliance with the rules and regulations of treatment, encouraging the inmate to accept "ownership" of the norms of treatment, and motivating the inmate to make a firm commitment to positive change.

The Bureau has found that these objectives mesh well with traditional individual and group therapy as well as with positive

skill-building techniques. Treatment strategies are based on two premises:

(1) the inmate is responsible for his or her behavior, and

(2) the inmate can change his or her behavior.

The treatment regimen focuses on the inmate's individual accountability and responsibility, and attempts to help inmates change their behavior patterns so that they will not return to criminal activity or drug abuse after their release. The following skill-building approaches are employed to help accomplish these goals:

- Rational-Emotive/Rational-Behavioral Therapy, in which inmates learn about the impact of beliefs on behavior and learn to distinguish rational from irrational beliefs.

- Errors in Thinking, which focuses on correcting "criminal thinking patterns" and emphasizes the development of honesty, tolerance, respect, and responsibility.

- Communication and Interpersonal Relationship Skill-Building.

- Relapse Prevention, where each inmate develops an individual relapse-prevention plan that follows him or her through the institution to the community.

- Release Planning, which teaches practical community-living skills such as job seeking, house hunting, finding medical

treatment in the community, dealing with rejection, and distinguishing between realistic and unrealistic expectations upon return to the community.

In Fiscal Year 1998, 10,006 inmates participated in residential drug abuse treatment programs.

Research Results. Last year, the Bureau's Office of Research and Evaluation completed an important milestone in the evaluation of the effectiveness of the residential drug abuse treatment program in reducing recidivism and drug use among offenders released from prison, as well as reducing inmate misconduct. The results represent a 6-month follow-up of inmates released from Bureau custody, some of whom received treatment and some of whom qualified for treatment but did not elect to receive the treatment.

The report shows that the Bureau's residential drug abuse treatment programs have a beneficial impact on the ability of inmates to remain drug- and crime-free upon release from confinement. The study, conducted with funding and assistance from the National Institute on Drug Abuse, finds that among inmates who completed the residential drug abuse treatment program, only 3.3 percent were likely to be re-arrested within the first 6 months in the community, compared to 12.1 percent of inmates who did not receive such treatment; that is, those who completed the treatment were 73 percent less likely to be re-arrested than those who were not treated. Similarly, inmates who completed the residential drug abuse treatment program were 44 percent less likely than inmates who did not receive such

treatment to use drugs within 6 months of release from custody. Among inmates who completed the residential drug abuse treatment program, 20.5 percent were likely to use drugs within the first 6 months in the community compared to 36.7 percent of those who did not receive such treatment. Finally, the results show that program graduates had a lower incidence of misconduct than did a comparison group of individuals who did not participate in the program. The reduction in the incidence of misconduct among treatment graduates was 25% for men and 70% for women.

The findings are all the more encouraging because the first 6 months of an offender's release back to the community are particularly difficult. It is during that period that inmates are most vulnerable to a return to the lives they led prior to entering prison. This study indicates that drug abuse treatment assists inmates during this initial reintegration into the community. The results of the final report, based on a 3-year follow-up, will help us determine whether the positive effects continue beyond this initial period.

NON-RESIDENTIAL DRUG ABUSE TREATMENT

Program Eligibility. In addition to the 42 residential programs, non-residential drug counseling is available in every Bureau of Prisons institution. In non-residential programs, unlike residential programs, inmates are not housed separately in prison units reserved for drug treatment participants, but are housed in regular units with the general inmate population. Inmates with drug problems, who have minimal time remaining on their sentences, have serious mental health problems, or are otherwise

unable to participate in one of the Bureau's residential units can seek treatment by staff in the institution's Psychology Services Department.

Program Content. In non-residential programs, a licensed psychologist develops an individualized treatment plan based on a thorough assessment of the inmate. Treatment often includes individual and group therapy. Self-help groups such as Twelve-Step and Rational Recovery Groups are also available to provide support for recovering substance-dependent inmates.

The Bureau's non-residential treatment component also accommodates the need for a prison-based aftercare program for inmates who successfully complete the residential program and return to the institution's general population prior to their release. It is required of all residential graduates and includes a minimum of one group session each month for a year. Group activities consist of relapse prevention planning, a review of rational behaviors, and confronting thinking errors. In Fiscal Year 1998, 5,038 inmates participated in non-residential drug abuse treatment programs.

TRANSITIONAL SERVICES

When an inmate is transferred from an institution to a Community Corrections Center (halfway house) or released from custody to the supervision of the U.S. Probation Service, the final treatment plan/relapse-prevention plan is forwarded to the community supervising authority to ensure continuity in treatment. Once in the community, graduates of the residential

program (and other inmates in Community Corrections Centers who are identified as needing community drug treatment) are required to participate in treatment.

During the inmate's time in a Community Corrections Center, drug treatment is provided through community-based providers whose treatment regimen is similar to the Bureau of Prisons, ensuring consistency in treatment and supervision. Bureau Transitional Services Managers monitor inmate compliance with the treatment plan and ensure the inmate remains drug-free by monitoring his or her progress and requiring regular urinalysis testing.

In addition, inmates leaving Bureau custody for supervision with the U.S. Probation Office frequently remain in treatment while under supervision. This ensures continuity in accountability and treatment for the inmate during the critical community re-integration period.

In Fiscal Year 1998, the community transitional services program provided treatment for 6,951 inmates.

COORDINATING WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Bureau designed its current drug abuse treatment regimen to include state-of-the-art treatment models. The Bureau has always coordinated activities with different components of the Department of Health and Human Services, such as the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT).

The Bureau continues to coordinate program activities with agencies within the Department of Health and Human Services. For example, representatives from the Bureau meet with NIDA and CSAT representatives on a bi-monthly basis to exchange information on drug abuse treatment program initiatives. Workgroups and discussions regarding programs for female offenders, violent offenders, post-prison transition, and programs for inmates who have substance abuse and mental health disorders are some of the topics that have been discussed this year. Bureau staff also meet with staff from the Substance Abuse and Mental Health Services Administration annually to ensure that technical reporting requirements are compatible.

CLOSING

Mister Chairman, this concludes my formal statement. I would be pleased to answer any questions you or other Members of the Subcommittee might have.

Mr. MICA. Thank you. We will start some questioning. I will lead off. First, I want to ask Mr. Schecter with ONDCP a couple of questions.

We have had the report that was released yesterday on the Institute of Medicine's findings on marijuana as a medicine. I think we have had dozens of other studies that have already demonstrated that smoking marijuana is dangerous and lacks any medical utility.

It is also my understanding that a recent Canadian journal said that the United States might start clinical trials of medical marijuana. I think in the report there is some indication that might be the next step.

Subsequently, the FDA has said that it has approved clinical trials. Can you tell us about that report or the status of what the next step might be that is anticipated?

Mr. SCHECTER. Mr. Chairman, I have not seen that journal. I would really probably have to defer to NIDA on what their plans are for clinical trials.

Mr. MICA. Does your office have a position on clinical trials? Are they recommending that as the next step?

Mr. SCHECTER. No. I think General McCaffrey's position on this is that they have gone through a great deal of time and trouble to assemble and review the scientific evidence. They have presented their findings. The ball is now really in the court of NIH and other agencies to determine what, if any, next step is appropriate, given their own research priorities and the needs for developing this.

Mr. MICA. So, your recommendation would be against further clinical studies?

Mr. SCHECTER. Well, again, I would defer to HHS on that question.

Mr. MICA. Mr. Millstein, do you want to comment?

Mr. MILLSTEIN. If you are talking about the clinical trials, sir?

Mr. MICA. Right.

Mr. MILLSTEIN. That is the province of the Food and Drug Administration. The role of the National Institute on Drug Abuse specifically is by international treaty, we hear, the only organization that can supply marijuana for research use in this country. That is a rule formally held by the DEA and by NIDA.

Mr. MICA. What would be your recommendation; that you want to go forward with that or do you have a position regarding clinical trials?

Mr. MILLSTEIN. If you are speaking, sir, about the recently released report by the Institute of Medicine, of course, that has just been released yesterday and it has been received by the Department. It will be reviewed there. The Food and Drug Administration, the National Institutes of Health, and the Surgeon General will advise the Secretary.

Specifically, as to NIDA's role, it is only in providing the marijuana after others make a determination that a study should be——

Mr. MICA. So, you will not get involved in either recommending for or against any trials?

Mr. MILLSTEIN. The Director of the National Institutes of Health might have a different role than we do. Because the National Institute on Drug Abuse has, as its mission, solely the use of dollars for

drug abuse, we have no role in any so-called medicinal or medical use of marijuana.

Anything that would be for any particular disease entity would be the province of a different institute and the National Institutes of Health.

Mr. MICA. Does this Substance Abuse and Mental Health Services Administration, Dr. Autry, have a position?

Dr. AUTRY. Let me answer that for the department as a whole, rather than for any one of our given agencies. The department really has not analyzed the IOM report and come to a decision on that issue yet.

This will be a high priority policy issue that we will have to have discussions across all of the agencies that might be involved in this. We will certainly keep the subcommittee informed on those decisions. We do not have a position at this point.

Mr. MICA. Mr. Schecter, you spoke about some reports that indicate that we have fewer users. I guess that is primarily an adult group. But we have more deaths and we have more use by teenagers or our youth population.

How is ONDCP trying to address the problems of the additional deaths and the use with our younger population?

Mr. SCHECTER. Well, you raise a very good point. We have, I think in this country today, an increasingly two-sided drug problem.

We have a situation where there are fewer individuals using drugs, yet at the same time, almost paradoxically, the number of drug-related medical emergencies has been rising.

The number of drug-related deaths has been rising. The economic impact of drug abuse on American society has been rising, despite the drop in the number of drug users.

Mr. MICA. And we have more people in our prison than ever before.

Mr. SCHECTER. That is true too.

Mr. MICA. And more there because of some drug-related offense.

Mr. SCHECTER. The reason for this seems to be that what is not decreasing commensurately is the number of chronic or hard-core drug users. Their number is difficult to gauge with accuracy, and we have been trying to do a better job of doing this with the Chicago study and so forth. The number of chronic users seems to be holding rather steady and, at the same time, aging. So, consequently you get people who are much more likely to be overdosing, to be developing medical problems which get them into hospital emergency rooms, causing crimes, and so forth.

Now, the answer to this I think lies in a couple of areas. One is closing that treatment gap—particularly, doing a better job targeting the treatments to where it is needed. SAMHSA has a Targeted Capacity Expansion Treatment Initiative, which we think will be very successful in getting those hard-core users into treatment.

Another way to do that is using the criminal justice system more effectively, because that is where so many of these individuals end up.

You also mentioned the problem of young people. That is yet another facet of this drug situation which is becoming increasingly complex.

The number of overall drug users has been going down and then holding steady for the last several years. Teen drug use has, during the 1990's, increased and now apparently is starting to level off.

What you have, as you pointed out in your statement, is more teens now starting to get involved in some of the extremely dangerous drugs like heroin. So, you have the situation that occurred in south central Florida, in the past year or so, where there was a number of drug-related deaths due to heroin. One of the ways that we have got to deal with that issue over the short-run is to get the word out to these kids about how dangerous heroin is.

Heroin has not really been a high visibility drug problem in this country for probably 20 or 30 years. That was the last real heroin epidemic we had.

So, certainly the younger generation has tended to, not be aware of how dangerous heroin is; particularly, now that you have got the high-purity heroin. You do not have to inject it. You can take it nasally, pop it through the skin; other means of administration which do not appear to be so threatening as injection. So, we are using our media campaign to get some effective anti-heroin messages out there.

Mr. MICA. Well, one of the things that concerns me is that this administration has spent more time talking about tobacco from the beginning. I think the recent statistics that I just heard within the last week is that we may even have an increase among youth, the use and probably addiction to tobacco.

Within the last 2 weeks, I sat down with a group of young people, all who were committed either by court sentence to a drug treatment program or I think there were several in there who had volunteered.

They did not have much of a choice. It was either volunteer or be sentenced. Two were there because of alcohol-related felonies, but the balance of maybe 25 were all there because of drug abuse.

I asked them specifically had they seen any of the ads that have been put on of late, which you all have been touting and we financed? They all shook their heads, yes. Then I asked them what they thought of them.

They all just started laughing. I asked them about the ads. They thought they were completely useless. They said that in today's media barrage and barrage of violence and other things that they are exposed to, that they had no impact.

They thought they were almost a waste of money. Now, I am not going to spend the rest of the hearing on that. We are going to have a specific hearing. We have questions to you examining what is going on with the sizable amount of taxpayer dollars we are putting into that.

I have no problem putting $1 billion every week into it, if we had to, to solve the problem. But we want to make sure it is effective. What is your response? For example, there is no 800 number on the ads.

Then I understand in your program where you do have an 800 number, that you get an automated response. That you do not talk to an individual. Maybe you could just respond to the points I have raised.

Mr. SCHECTER. Yes. First, let me respond to your point about the kids. I am not completely surprised that they had that reaction. The goal of the campaign is not so much to change the minds of kids who are already starting to get involved with drugs or who are already in trouble with the law.

It is really targeted to a somewhat younger group; the kids who are just on the verge of that kind of activity to try to shift their attitudes before drug use behavior begins.

Mr. MICA. All right. But now, go back and do another focus group. Thank you. The balance of the response; the 800 number.

Mr. SCHECTER. I believe most of the print ads do have an 800 number on them, except for the matching ads which may not. Sometimes, it is hard to distinguish which is a pro bono match ad and which is an ad paid for directly by the campaign.

As far as the automated response, a part of that problem is we are victims of our own success. We are trying to deal with that to make sure that everybody does talk to an individual. That there is as short a wait as possible.

Mr. MICA. Thank you. I would like to yield now to our ranking member, Mrs. Mink.

Mrs. MINK. Thank you very much.

There is considerable discussion about the youth media campaign and a hope and expectation that it will be effective. How much money actually is being spent on that program in terms of it being out there actually in it commercials on television, excluding the administrative production costs?

Mr. SCHECTER. Of the $185 million appropriated for this past year, my recollection is the amount of money that is devoted to ads is something like, I could be wrong, but it is on the order of $157 or $158 million.

The rest of the funding is for other types of media. It is a multimedia, not just an ad, campaign. We have a major Internet component, for example, that will be announced next week, which is very exciting.

Of course, some money goes to the contractors who place the ads and handle the other administrative requirements, but that is a very, very small percentage.

Mrs. MINK. So, most television programs and others make a survey or conduct a poll to see what the reach is in terms of the targeted population. Do you have any information as to whether you are reaching that age group that those ads are targeted to?

Mr. SCHECTER. Yes, we do have tracking surveys that our contractors conduct.

That is how we know and can speak with confidence that we are reaching at least 95 percent of the teen target audience, an average of about 6.7 times per week, which averages out to about once a day.

Mrs. MINK. Now, if we are spending $165 million on the ad program, what is the value of the pro bono contributions that you are receiving in the form of PSA's?

Mr. SCHECTER. Again, we are exceeding our projections. When we first began this campaign and predicated it on a dollar-for-dollar match, we frankly had no idea whether that was going to happen; whether the industry would really be able to match to that level.

What is happening is we are exceeding that projection—about 107 percent matching. In other words, we are more than matching dollar-for-dollar. In addition to that, there is about another $40 million in other contributions from private industry that have come along as a part of this campaign.

Now, later this summer, we will be letting a contract for a new corporate participation program which will vastly increase still further the level of corporate contributions to the campaign.

Mrs. MINK. So, what is your expectation in terms of the outcome, in terms of reducing the young people turning to drugs and becoming persistent drug users?

Mr. SCHECTER. There is a graph in the strategy which really shows what we are trying to do. It plots teen drug use.

[Chart shown.]

Mr. SCHECTER. You can see that line coming down through the 1980's and then turning up again during the 1990's, and leveling out the last couple of years. Then you have got two other lines which are absolutely perfectly inversely proportionate to that line.

In other words, as drug use is going up, the perception of risk is going down. The perception of social disapproval is going down. This is measured on Dr. Lloyd Johnston's Monitoring the Future survey at the University of Michigan.

You have perception of risk going down. This campaign is targeting those two attitudes, trying to again shift those trend lines back in another direction.

What the research shows is that when those attitudes start heading the other way, teen drug use, within 1 to 2 years, starts heading downward. That is what the campaign is trying to achieve.

Mrs. MINK. Just one final question because I have a second round. You talked about the Drug Free Community Program and the partnership and how effective it is. Why is it that in the administration's budget or your office budget you have reduced the funding of that program?

Mr. SCHECTER. The authorized ceiling for that program is $30 million for fiscal year 2000. The administration's request is $22 million. We would, of course, welcome discussion with the Congress about different funding levels.

I think it is probably no secret that General McCaffrey initially proposed both to OMB and to the President a higher level. But $22 million is the administration's position.

Mrs. MINK. The other aspect of that is the maximum amount of funding for the Community-Based Coalitions. You also have set very low caps in the next 3 or 4 succeeding years. What is the reason for that?

Mr. SCHECTER. The law says that the Administrator and the Director of ONDCP is authorized, to award continuation grants in the 2nd, 3rd, 4th, and 5th years of the grants. It prohibits any up-front multi-year funding.

So, the decision before the Director, first of all, was whether to award continuation grants. That was an open question. Second, if so, what would the policy be, keeping in mind two goals that we have and that the Congress had with this program.

One goal is to support strong, healthy, vibrant coalitions that will be able to stand on their own feet, both financially and otherwise, with strong local support.

Second, our goal is to increase the number of such coalitions around the country. Based on recommendations from the Department of Justice and after discussion with the Advisory Commission, this is the Presidentially-appointed Advisory Commission on Drug Free Communities that met back in November, the Director made a decision to award continuation grants. But he decided to reduce the amount of funding in the 2nd and 3rd year, and commensurately increase matching to provide a strong incentive for communities to increase, broaden, and strengthen their base of local support.

Mrs. MINK. Thank you, Mr. Chairman.

Mr. MICA. I thank the gentle lady. I now recognize the gentleman from Indiana, Mr. Souder.

Mr. SOUDER. I want to say for the record that was an unacceptable answer. Mr. Schecter, I am not used to seeing you in America. We were in Mexico the last time we talked.

I would think that those of us in Congress who worked on the bill, who helped put that bill together, who put that language in, who worked with community groups to try to get the processes in, would have been consulted in that process as well.

We were specifically not consulted in any work there. Furthermore, you said you talked to them in November. Did the Advisory Commission know, at that point, that you were not going to seek additional funding, and it was not going to be fully funded?

In other words, did the Commission get told that if in fact, the people who already had the grants and already submitted a plan, while I understand that it was not locked in, that it was going to be there?

I do not know of very many grants that you do not assume that the funding is going to flow, unless something—in other words, that there is going to be a sea change in the middle of your process.

I am not arguing that they were not told up-front that this is not guaranteed. But when you present a multi-year plan, and here is the amount of money, it is not an illogical jump to conclude that it is going to be a continuation, unless you do something wrong.

Furthermore, you certainly do not assume that you are going to get the size in draconian cuts that were there. You said that the Advisory Commission, based on their input, that the Director made the decision to reduce this.

Did they know the size of these cuts? Did they know what the budget was going to be? Were they given the impression that there would be minimal and additional groups added in the process? Besides, we were not consulted.

Mr. SCHECTER. I take your point, sir.

At the November meeting of the Advisory Commission, going back, I am looking over the minutes of Shay Bilchik—who is our Grants Administrator, head of the Office of Juvenile Justice and the Delinquency Prevention at Justice—we put into play for the commission's consideration a policy of a reduction of about 25 percent in the next year.

They discussed that and on through lunch. In fact, one committee member at one point said, "Well, we will let you, the staff, work out the details. We could talk about this endlessly."

What they were very clear on, put in their minutes, and recommended to the Director, was that there be a clear policy of reducing the Federal share of the budget in each succeeding year.

They then left to the Director his best judgment of what exactly those levels should be. Again, of course, they were aware of this proposal on the table for a 25 percent reduction and did not view that as out of line.

Mr. SOUDER. It may put us in the position of having to make more clear direction, rather than leaving discretion, because rural groups, for example, and some urban groups who are many of the targets of this program do not have the flexibility to go out and raise the private sector match as easily as a suburban group would.

I, myself, am not sure. I have a fundamental distrust of whether this is not a budget gimmick where the administration in fact comes in with a lower budget request by altering existing grants.

Although I agree, it was not mandated, but the understanding of those groups, certainly in my District, that was not how they understood the process. I am not saying they did not jump to a conclusion, but that was not their understanding.

Then putting political pressure on us to do something in the budget that the administration did not have the courage to do. It does not breed trust in the relationships when it was a project that was bipartisan and one that we are trying to put together.

I also have a similar concern on drug free work places. You talked in your testimony about the Drug Free Work Place bill which came originally through my subcommittee that I Chaired at the time.

I Chaired that bill and worked it through, but the President's budget, I believe, does not have any funding in it for drug free work places. Is that correct?

Mr. SCHECTER. I believe it does. I will have to check on that. I believe that is in there.

Mr. SOUDER. My understanding is that——

Mr. SCHECTER. It should be in the Small Business Administration budget. It would not be in ONDCP.

Mr. SOUDER. Yes, it would be in the Small Business budget because it was under the Small Business Committee that we funded that. I will double check that.

Mr. SCHECTER. Let me check on that, too, sir.

Mr. SOUDER. OK.

Mr. SCHECTER. I will provide an answer.

[The information referred to follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

May 21, 1999

The Honorable Mark Souder
United States House of Representatives
Washington, D.C. 20515

Dear Representative Souder:

This responds to your letter concerning the Administration's support of drug-free workplace programs. These workplace initiatives are a very important component of our *1999 National Drug Control Strategy*. Three of every four drug users actually are employed. It is essential that we use every means available to encourage drug prevention and intervention programs in places of employment. We appreciate your support and leadership of drug-free workplace programs. Congress has made a major contribution to the national drug strategy through its support for the Drug-Free Workplace Act of 1998.

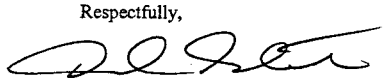
You are correct in noting that the President's FY 2000 budget for the Small Business Administration (SBA) does not include funding for the Drug-Free Workplace Act program. This omission, notwithstanding the *Strategy's* strong endorsement of drug-free workplace programs, is the result of two factors: the SBA's lack of a significant historical drug control function and the timing of the appropriation.

As you know, the Drug-Free Workplace Act of 1998 and FY 1999 Emergency Supplemental Appropriation were passed early in fiscal year 1999, as development of the President's FY 2000 budget was nearing completion. As a result, the Small Business Administration had very little opportunity to provide for continuation of that program in their submission. As ONDCP develops budget guidance to agencies for the FY 2001 budget cycle, we will indicate to SBA that drug-free workplace programs should be made a priority in their budget submission.

The Drug-Free Workplace program represents a new thrust for SBA. ONDCP and drug-free workplace program experts from the Department of Labor and the Substance Abuse and Mental Health Services Administration have been providing technical assistance to SBA on their implementation of the program. Current plans are to designate $1 million for Small Business Development Center grants. The remaining $3 million will be in the form of grants with eligible intermediaries to provide financial and technical assistance to small businesses to establish drug-free workplace programs. These grants will provide outreach that will include education of small businesses on the benefits of a drug-free workplace and encouragement of small business employers and employees to participate in drug-free workplace programs. Availability of the 12-month grants has already been advertised in the Commerce Business Daily. The expected award date is in July.

Your questions concerning the Drug-Free Communities Program continuation grant policy were addressed in a letter to you from Director McCaffrey dated March 29 (copy enclosed). We appreciate your continued support as we work together to reduce drug abuse in America.

Respectfully,



Daniel Schecter
Deputy Director for
Demand Reduction (Acting)

Enclosure

Mr. SOUDER. I wanted to follow up too on the media campaign. By the way, I want to say first off, I think this is a comprehensive campaign in prevention and treatment. I want to applaud you with that.

We are here in an oversight function and I am asking aggressive questions. First off, I want to say to all of you, this is the type of thing we need. It does not mean that I do not have a lot of fundamental questions underneath that to fine tune it.

I do have some concerns as you are hearing from a number of our members. I believe that if we do not get ahold of the medicinal use of marijuana question, all other questions are pretty well defeated.

I wanted to zero in, if I could just briefly, Mr. Chairman, on the concern about the media campaign. On Monday, I am at the Education Committee, where we are working on the Elementary and Secondary Education Act.

We have been going to a lot of different schools. I asked a group of students if they had heard about the medicinal use of marijuana debate. The answer was uniformly yes.

What did they think? They uniformly thought it should be used for medicine. I asked them if they realized that there were, I think, 270 different chemicals in marijuana and it is just one that is in fact the critical chemical?

Here you do not have to have marijuana to find that chemical. They said they had never heard that before. Now, that was particularly troubling.

How can we have a media campaign, and how can we have a national effort that does not in fact speak to the fundamental challenge we are having right now in the 8th and 12th grades?

As you all have eloquently pointed out, we are making headway in college students. We are going to make more with our drug testing and student loan criteria which every university is going berserk about right now, but which is putting the pressure on at the college level.

We are making at least stabilization and some headway among adults, and 8th graders generally do not start with heroin or cocaine. They are starting with marijuana, tobacco, and alcohol.

If they believe that marijuana is medicinal, how in the world are we going to win this battle? Do you not believe that our materials actually ought to be focused, first and foremost, at the primary point where the growth in the drug abuse is occurring? Why would that not be a part of our national media campaign?

Mr. SCHECTER. Well, we reached very much the same conclusion. Right now, we are in phase II of this campaign. This means that it is a national campaign, but it is essentially using media spots that had already been created through the Partnership For Drug Free America—essentially off-the-shelf ads.

The problem with this is that the inventory of good anti-marijuana ads targeted to the age group you just referred to—which really is the critical age group was very, very small.

We are having to make do with what we've got. However, we told PDFA that our top priority for new ad development was exactly those kinds of ads; ads that dealt with marijuana for middle school aged kids.

We have now previewed in the last several weeks a number of new ads that they are developing which are absolutely superb.

They are some of the best spots I have ever seen and that General McCaffrey has ever seen. Those will be coming on-line in the next couple of months.

Mr. SOUDER. I hope we will see a focus beyond just the students and reach beyond that point. I want to say, first of all, bravo for doing that. That is the at-risk market. We need to see an aggressive effort there.

Then moving to the high school market and see where we are going in the general public. Clearly, this advent of opening the door to drug legalization is a disaster in this country.

Thank you for letting me go over my time.

Mr. MICA. I thank the gentleman.

I would like to recognize the gentleman from Maryland. Would you allow me one 30-second question? Joseph Autry, the Substance Abuse and Mental Health Services Administration, I think you put in our packet these, I guess, how much funds flow into each State. Is that correct?

Dr. AUTRY. We developed specific State data for each one of the members.

Mr. MICA. Can you provide me that information by next week, I want to know how many people administer this program?

Dr. AUTRY. Sure, we can do that.

Mr. MICA. I want to know how many Federal folks administer that program. If you would followup and get me that information?

[The information referred to follows:]

SAMHSA has approximately 26 FTEs assigned to administration of the Substance Abuse Prevention and Treatment Block Grant. This number represents all staff involved in administration of the grant including those responsible for providing technical assistance to the States.

Mr. MICA. Thank you. I yield now to Mr. Cummings.

Did you get one, too? I think your goodie bag is in there. I am pleased to recognize the gentleman who has the distinction of officially having 39,000 heroin addicts.

The unofficial figures he tells me are much higher; the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. That is certainly not a good thing.

Thank you, Mr. Chairman. I want to thank you and our ranking member, Mrs. Mink, for having this hearing because it is a subject that is near and dear to me.

First of all, let us note that most of the questions have been directed to you, Mr. Schecter. I have just a few. I must tell you, there is not a lot that I agree with my friends on the other side.

One thing I am concerned about is the Drug Free Communities Act and this reduction of funding. The reason I say that is because there are so many community groups that are trying to fight this drug problem.

In my area of Baltimore, it takes a lot of nerve for people to do what they do. Literally, their lives are threatened daily. I have said it before, I live in fear everyday. Every night when I sleep, I am in fear because I see what is happening in my community with regard to drugs.

So, whenever you have a program where community groups are willing to band together and to stand-up to fight the drug element, I think we need to be doing more and not less. It concerns me. I wanted to ask a question of our friend from the Bureau of Prisons, Dr. Verdeyen. One of the things that has always concerned me, having practiced criminal law for 18 years and talking to the criminal element in the State prisons.

It seemed as if you could get drugs just as easy in prison as you could get them out of prison. I could never figure that out. It concerns me that just this past week or two we had a show on local television in Baltimore where they are talking about trying to help people who were in prison, and still on drugs.

The drug problem got worse in prison, and trying to figure out a way to help them was difficult. See, there is something wrong with that picture. I mean, maybe I am missing something.

I thought prisons were supposed to be pretty much air-tight and definitely drug-tight. Then when I think about our Federal prisons, they are supposed to be tighter. I am wondering what your view is on that?

Do we have major drug problems in our prisons? When I say "drug problem" I want to be real clear. I mean, drugs coming into our prisons.

Ms. VERDEYEN. I have the most recent information. Actually, it is information for this past year on the random drug testing that we do on offenders in Federal prisons. Our screens came up as 1.1 percent of those tests were positive.

So, while it is not air-tight, it is not a huge problem. We have a number of approaches to prevent drugs from coming in, having to do with surveillance in the visiting rooms.

We have introduced the ion scanners in 28 of our institutions. That seems to be effective in deterring people from even trying to bring drugs into the visiting areas.

Mr. CUMMINGS. Maybe we need to try to do some of that in the State prisons. Do we have somebody here from the State prisons?

Ms. VERDEYEN. I believe so.

Mr. SCHECTER. Sir, this is exactly the purpose of Drug Free Prison Zone demonstration project that I was talking about in my opening statement.

Mr. CUMMINGS. I apologize. I was in another hearing.

Mr. SCHECTER. Oh, I am sorry. That is true.

This was a $6 million appropriation that came to ONDCP last fiscal year. We entered into an agreement with the Justice Department to divide that among the Federal prisons to put ion scanners into some of these Federal facilities so that when people are trying to bring drugs into the prison, they will get detected.

Then $4 million was awarded competitively to 8 States to implement different types of procedures and programs, including better training for staff on how to intercept drugs coming into prisons, and also to institute drug testing.

Mr. CUMMINGS. Did he just pass you a note that Maryland is one of them?

Mr. SCHECTER. Maryland is one.

Mr. CUMMINGS. I know staff. I mean, you have got to get that in. I did not know that, but I am glad to know that, brother staff member.

So, how long have those grants been out there?

Mr. SCHECTER. They were just awarded, I think, in January.

Mr. CUMMINGS. January; OK, good.

Let me ask you something. What are we doing with regard to sales persons of drugs? Let me just tell you. In my community, a part of the problem is that young men, and there are a lot of women, they do not use drugs but they sell them because they cannot find jobs, so they claim.

When I came home last night, literally within a block of my house, I got home around 12 o'clock. There were about 14 or 15 young people standing on the corner within a block of my house, which is right near downtown Baltimore, selling drugs.

I am just wondering, I mean, do we aim anything at dealing with these sales people?

[No response.]

Mr. CUMMINGS. Hello. Anybody?

Mr. SCHECTER. Yes. There are a number of programs like that. Karol Kumpfer may have some examples from CSAP. There are media campaign spots that target that kind of activity. There are some other prevention programs.

It is very difficult to reach these kinds of kids. What you are really talking about are not so much programs targeted at selling drugs, but programs targeted at a whole range of negative, high risk, and counter productive behaviors in the school systems.

I might ask Karol to speak to that.

Mr. CUMMINGS. While you are pulling the microphone closer, one of the interesting things that we've seen, and heard about drug sales in the black communities.

You turn on the 6 o'clock news and people, if you just looked at the television, you would assume that most of the people on drugs, using, and selling drugs are black. Well, dah. They are not. They are white.

I think all of you all know that, but the picture is thrown out there that they are black. One of the interesting phenomenons that I have seen here lately is how in our suburban schools, where you have these majority white populations like 90 percent to 95 percent, they are now discovering major sales persons in the schools with big time corporate activity selling drugs to our youngsters.

So, I am not just aiming it at my street. I am also looking at the streets outside of my neighborhood.

Ms. KUMPFER. One of the things that I wish is that we could market prevention as well as they market drugs. That is one of the things that we are working on at the Center for Substance Abuse Prevention.

You are right about being concerned about that for a number of reasons: in terms of youth selling because, not only do they sell but, eventually, most of the data shows that they eventually get into using drugs.

They think they are only going to start making some money, but they get involved in the whole drug culture. Eventually, the stress,

the pressures, the money, and all that, they end up using quite often as well.

What we are doing at the Center for Substance Abuse Prevention is: we recognize that it takes a coordinated, comprehensive, community-based approach to be able to help youths not to use drugs—which involves working with the whole community, changing the atmosphere and the environment, helping kids to have productive lives—in other ways that they are not going to want to use or not want to sell drugs.

Effective programs that would deal with this more directly are going to start right in the home, very early, with having a strong family: where the kids understand that this is not within the family values and norms that they should be selling drugs.

The parents monitor their children and are close enough and connected to their children that they know what their children are doing and where they are.

Then also when you get to the junior high and high school level, you can start working on having the children be involved in positive activities so that they are involved in community service activities through their schools, through their churches.

They start learning that there are more effective ways for them to make money and develop skills and competencies in this world. We have also been working with one of our grant programs. It is Project Youth Connect, which is to involve those youth with mentors.

We have funded a number of grants around the country this last year through the High Risk Youth Grant Program to train mentors to work with youth to then support their communities through doing a number of different kinds of activities with youth in the community. It would also involve community service projects as well.

Mr. CUMMINGS. What is the average amount of those grants? I am just curious.

Ms. KUMPFER. The average amount is around $400,000 to $500,000. They are funded at a pretty good size level.

Mr. CUMMINGS. Do you know if Maryland got one?

Ms. KUMPFER. They were incredibly popular, I might say also. We had a huge number of applications for a very small amount of money. We only had $7 million this year. Excellent grants, we could not even fund, though they were very, very popular.

Mr. CUMMINGS. Thank you.

Mr. MICA. My friend from Hawaii has questions.

I am going to yield the floor.

Mr. OSE [presiding]. This is the first time this junior member has sat in the chair.

Mrs. MINK. Oh, you want to sit there awhile.

Mr. OSE. I am terrified I am going to screw it up.

Mrs. MINK. For my colleagues' benefit, we are going to have another hearing on the law enforcement end, where the questions that you are pursuing, which I am very much interested in, also can be pursued at that time with the law enforcement agencies. I have a question to Ms. Verdeyen.

Ms. VERDEYEN. Yes.

Mrs. MINK. The prison population that you referred to in your testimony is basically the Federal prisons; correct?

Ms. VERDEYEN. That is correct.

Mrs. MINK. That is a very small number when you consider the 1.8 million that are in our prisons throughout the country, local jails, State prisons, and so forth.

Now, to what extent is the program that you described also in place in the State prison systems so that what you are doing to identify the prisoners that are drug-dependent and putting them into a treatment program?

To what extent is that happening in the State prison populations? We are talking about 100,000 Federal prisoners, as compared to 1.6 million prisoners in the other systems. These are the individuals who are going to be released and eventually come back to our communities.

If treatment in the prisons is going to make any difference, we have to find a program that relates to that population. Can you comment on that?

Ms. VERDEYEN. Our programs are available to States through the National Institute of Corrections. Our curriculum that we use—I do not have information on——

Mrs. MINK. How do you get it out to them? Are there grants to States? Is there financial support? We talk about partnerships in the communities. Is there partnering in terms of what you are doing with our local prisons so that the practices that you find successful are translated to them? Perhaps we have to enlarge the program and make sure those are funded as well.

Ms. VERDEYEN. That information would be from the Office of Justice Programs. I would be happy to see that you get that information.

Mrs. MINK. Meaning that they have money that they allocate to the States for that purpose?

Ms. VERDEYEN. Yes.

Mrs. MINK. Do you have any idea how much that is?

Ms. VERDEYEN. No, I am sorry.

Mr. SCHECTER. Mrs. Mink, there are some programs in the Justice Department, although not in the Bureau of Prisons areas that do this. For example, there is, as I mentioned earlier, the Drug Intervention Program, which is unfunded. It is a $100 million request.

That would institute system-wide drug intervention and treatment programs throughout all aspects of the criminal justice system in an area. There is also, of course, the Break the Cycle Program, which you may be aware of.

There are a limited number of demonstration sites around the country. Again, through a similar kind of systemic approach to drugs in the criminal justice system.

Mrs. MINK. Why has that remained unfunded; because the funds were not requested or that the Congress refused to fund it?

Mr. SCHECTER. The funds were requested last year. I believe the request was $85 million. That was unfunded.

Mrs. MINK. What about in this year's budget?

Mr. SCHECTER. This year, the request is $100 million.

Mrs. MINK. So, it is before the Appropriation Committee now on both sides?

Mr. SCHECTER. Yes.

Mrs. MINK. What are the prospects of getting that money? It would seem to me that it is a terribly important area.

Mr. SCHECTER. It is certainly one of our high priorities. We are going to fight very hard for it, as is Attorney General Reno.

Mrs. MINK. Is it a correct statement that of the 1.8 million persons who are in the prisons that 60 percent of that population in some way got into prison because of their drug use, or drug dependency, or selling of drugs, or related in some way to the drug traffick? Is that a correct figure.

Mr. SCHECTER. There are various figures and they are all pretty high. It is hard to know which one is most accurate. It depends upon how you define it I guess.

Mrs. MINK. Is there a higher figure than 60 percent?

Mr. SCHECTER. I am sorry?

Mrs. MINK. Is there a higher figure than 60 percent drug related?

Mr. SCHECTER. That is about as high as I have seen.

Mrs. MINK. It seems to me that this population is going to get out. They are not going to be in prison, you know, for life, I do not think so. Although some of the sentences are pretty stiff.

This population is going to get out, go back into the communities, and unless we have adequate treatment of these prisoners in the State system, we are just going to compound the problem for ourselves when they get back in.

So, it seems to me this has to be a priority in terms of the demand situation.

Mr. SCHECTER. We agree 110 percent.

Let me cite one other program that I neglected to mention; the Residential Substance Abuse Treatment Program; $62 million at the Justice Department to support Residential Treatment Programs in State prisons.

Mrs. MINK. I just have one other area that we were talking about earlier. That is the medicinal use of marijuana. It is a very controversial subject. I differ with my colleagues on the majority on that subject.

It, nevertheless, I think, requires some scrutiny in terms of how we deal with the subject area. You have made the distinction that the Institute of Medicine did not indicate that smoked marijuana had any particular medicinal value. That the emphasis is going to be on the chemical compounding of it. Now, is there some way that, that kind of information can be extracted and formulated in a way that the people will accept that distinction?

Are we talking about a general topic of marijuana being something that has value and therefore completely compromise the efforts that you are making to indicate that it is not a suitable item for anyone, not only the youth, to be using?

Mr. SCHECTER. I think one of the real strengths of the IOM report is that they took great pains to distinguish between the two.

Mrs. MINK. Could you distinguish the two for this hearing so that it would be as clear as possible, given the limitations of language?

Mr. SCHECTER. Absolutely. Again, what the IOM is recommending is that there be further research into the various cannabinoid compounds contained within the raw marijuana plant.

There are a great many compounds. They are very complex. Most of them are not very well researched yet, but there is promising evidence, including some very new research showing how cannabinoids affect the brain, that suggest that there may be some potential uses.

One of the compounds has already been developed for commercial use. It is called marinol. It was developed in the 1980's. The IOM is suggesting there may be some other potentially useful compounds as well. As you have said, with regard to smoked marijuana, the raw plant that you roll up and light, their finding is: little to no medical potential.

Mrs. MINK. In dealing with this subject matter, is it necessary to go back to the marijuana plant for the manufacture and creation of the compounds that they are dealing with?

Is it a chemical compound that can be found distinct in the chemical laboratories without having to make a reference to marijuana? That is really my question.

Mr. SCHECTER. These compounds can potentially be synthesized. This is getting beyond my level of scientific knowledge.

Mrs. MINK. I read that explanation in a newspaper. It seemed perfectly clear, but nobody has said it today. So, I am somewhat mystified as to whether that is an accurate distinction in that report. If so, why that has not been utilized by any of you in clarifying the subject.

Mr. MILLSTEIN. Mrs. Mink, if I can answer your question.

Mrs. MINK. Yes.

Mr. MILLSTEIN. The substance drenavenol marketed as marinol is a synthetic substance. It is the psychoactive ingredient of marijuana, zeltinyne tetrahydrocanavanol. It is a synthetic substance, not made from the plant material.

Mrs. MINK. So, why are we in this discussion at all when we are talking about drug abuse, then, if it is like any other prescription; something that is synthesized chemically and sold as a prescriptive drug?

Why do we have to relate it in any shape or form to clarify as to whether there is any value to marijuana consumption?

Mr. SCHECTER. My understanding is that these compounds, of course, exist naturally in the marijuana plant. So, that is where you would first attempt to isolate them.

Mrs. MINK. But they are non-existent in any other circumstance.

Mr. SCHECTER. Apparently, they are quite rare otherwise. I think there are possibly some other plants that may exist.

Mrs. MINK. So, that you cannot get out of the discussion then.

Mr. SCHECTER. Once you do isolate them from the raw plant, then it is possible to synthesize it in the laboratory.

Mrs. MINK. But you need to have the plant.

Mr. SCHECTER. Initially.

Mrs. MINK. "Initially" meaning what? In every instance?

Mr. SCHECTER. Initially to identify and isolate what the compound is.

Mrs. MINK. Only for research purposes, but for the manufacturing as well?

Mr. SCHECTER. For manufacturing, you do not need the plant. You can manufacture it.

Mrs. MINK. It can be synthesized in a laboratory. Is that correct?

Mr. MILLSTEIN. The fact is that there are androgenous, that is within the body itself, cavanoids and canabidials. There is, I guess in theory at least, the possibility that there can be a derivation.

Mrs. MINK. Do you mean taking my body?

Mr. MILLSTEIN. In theory one could say that because——

Mrs. MINK. Well, this is far too complicated for me.

I yield the floor.

Mr. OSE. I heard that last exchange. In California, we have recently had the opportunity to vote on the use of marijuana for medicinal purposes.

What I failed to understand, particularly given my colleagues' questions, is that if we have the ability to synthesize marinol, for instance, and we have not yet been able to identify these other compounds that might come from smoking marijuana, why are we spending $1 million to study the use of smoked marijuana?

I do not grasp this. I want to come back to that point. I know Mr. Mica has spent some time on it. I am hopeful someone can explain it to me. My concerns are pretty straightforward.

There are enough clinical studies to establish that smoked marijuana lowers someone's immune system. It causes DNA, lung, heart, and epidemiological damage, that is according to some European studies.

It is a Schedule I Narcotic, according to U.S. Code. It has psychologically damaging affects. I mean, I know friends who have used it, former friends I must say. I do not have to have a doctor tell me about it.

Somebody needs to explain this to me.

Mr. SCHECTER. Common sense would suggest that you are absolutely right. However, we have an environment in which a number of States, including your own, were embarking on these public referenda where marijuana was the subject of intense debate about its medicinal properties.

Our view was that what we needed was a rigorous, up-to-date, state-of-the-art, unimpeachable review of exactly what the science said. As you say, there are a number of studies out there in various places, in various journals.

Different people will cite different studies. What we did not have was somebody that actually brought them all together, assessed them, peer-reviewed them, and determined exactly what the bottom line was, and reported back to the American public. That is what the IOM has done.

Mr. OSE. Let me back-up a minute. I have a hard time not being argumentative on this. So, be patient with me, if you would. It is my understanding that the Food and Drug Administration has that role.

What I am trying to understand is why are we branching out into ONDCP with that same role of studying the use of marijuana?

Mr. SCHECTER. Again, we do not normally do this kind of thing. We got into this simply because this was becoming a national pub-

lic policy debate. We did not see anybody else out there convening a blue ribbon group of scientists to review all of the existing research.

So, we thought that there was a need. It had not been done for a number of years. There was a fair amount of recent research that was worth looking at, including some very important research that Mr. Millstein alluded to on the natural cannabinoid in the brain and how cannabinoids affect the isolation of receptors in the brain.

So, somebody needed to take a look at that. It simply was not being done.

Mr. OSE. Let me go on to another question. If I understand correctly, ONDCP believes there are legal restrictions to developing and using advertisements that debunk the notion of marijuana as medicine. Is that correct?

Mr. SCHECTER. Well, the advertisements produced under our ad campaign do not directly address the issue of marijuana as medicine. What they address is the use of marijuana by kids because that is the target of the campaign.

Clearly, they communicate the idea that marijuana is a dangerous, harmful substance. That is the basic attitude that we wanted to instill.

Mr. OSE. Does the ONDCP believe that there are legal impediments to developing and using advertisements that debunk the notion of marijuana as medicine?

Mr. SCHECTER. No. I do not think there are legal impediments. I think there are statutory restrictions on using the campaign for a partisan political purpose. The problem is when you get into marijuana as medicine.

There are these various referenda in the States. They start getting into the area of public policy issues. What we wanted to target this campaign on was reducing teen drug use. So, everything in the campaign is focused on achieving that end.

Mr. OSE. I yield.

Mrs. MINK. Will the gentleman yield?

Mr. OSE. Yes.

Mrs. MINK. In the strategy book that I read, the executive summary; I have not really gone through the huge volumes. Repeatedly it suggests that one of the reasons why the whole issue of marijuana is so important is that, that is the beginning of the young person's experiment into drug use. Once they get into marijuana, it is quite likely that they will expand into other more difficult drugs like heroin, cocaine, and methamphetamine.

Therefore, in structuring an approach that will nip this potential growth of drug use among young people it is very important to hit the marijuana issue. Is that correct? Is my reading of the report accurate?

Mr. SCHECTER. Absolutely. In fact, the IOM points out in their report that the use of marijuana usually precedes the use of any other illicit drug.

Mrs. MINK. So, if that is true, and my reading is accurate then, I have a followup question. What impact will the validation of marijuana as a medicine have upon your overall media efforts to try to get young people to stay off of it?

Mr. SCHECTER. This was one of the things that has always concerned us about these ballot referenda and one of the reasons why we conducted this study. Indeed, the study now does say smoked marijuana is not beneficial.

Mrs. MINK. Suppose your clinical studies validate it as a useful relief from pain in terminal illnesses, no matter how it is structured?

Supposing it validates that, what impact will that have on our ability as a country to take hold of this whole issue of marijuana and get it under a controlled situation for our young people?

Mr. SCHECTER. We have long been concerned about the message that the whole medical marijuana movement, which is in many respects a thinly disguised legalization of drug movement is sending to our young people. There is no question about that.

Mrs. MINK. Thank you.

Mr. OSE. You are welcome.

Mrs. MINK. The microphone is yours.

Mr. OSE. Mr. Schecter, going back to the advertising issue on the use of marijuana and the comment about whether or not there are legal impediments to targeting advertisements to debunk the notion of marijuana as medicine.

If there are no legal impediments to that, and we have States that are considering referenda that would authorize such, why would we not target our advertisements in the immediate timeframe into those States. If we could, I would like to have you all come back to California and target California again.

Mr. SCHECTER. I wondered if, for the sake of wondering, whether if we were to do that, whether the other side on that public policy referenda would then demand equal time from the media.

Mr. OSE. They should come and ask Congress for funding.

Mr. SCHECTER. Again, I think the main reason for not doing that is that it is not central to the campaign's primary objectives. If you go back and take a look at the strategic plan for the media campaign, it states very clearly what the goals are.

What we wanted to avoid was having this campaign and the funds appropriated for it lose focus. There are various purposes that may be important and useful, but not central to the campaign.

The central purpose of the campaign, again, is to reduce rates of teen drug use. The campaign goes about that in the most direct way possible—in the ways in which research tells us are most likely to be effective.

Mr. OSE. How much clearer a message could one send than to go into States where they are actually considering the question of marijuana's medicine and make the case that it is not?

Mr. SCHECTER. My own view is that if you have effective ads out there showing the negative impact of marijuana on kids—and if I were a voter in that State and I saw those ads day in and day out—I think I would have a very different point of view when somebody came to me and suggested marijuana is medicine.

So, I think there is a connection. Again, what we want to do is keep the campaign focused on its initial goal: to reduce teen drug use.

Mr. OSE. Does ONDCP have the authority to concentrate ads in the States that are having referendums?

Mr. SCHECTER. I would have to talk to our lawyers to take a look at that to see looking at State laws, looking at the laws governing the campaign itself, the authorizing statute. I would have to get back to you on that. My impression is that would be a problematic exercise.

Mr. OSE. What does "problematic" mean?

Mr. SCHECTER. Meaning not necessarily legal, but I am not sure. Let me check on that and get back to you, sir.

Mr. OSE. We are going to leave the record open for a couple of weeks. So, we will take that feedback.

[The information referred to follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

August 26, 1999

Restrictions on Use of Media Campaign Funds for Anti-Marijuana as Medicine Initiatives Campaign

- The statutory authorization for the National Youth Anti-Drug Media Campaign requires the Director to "conduct a national media campaign in accordance with this chapter for the purpose of reducing and preventing drug abuse among young people in the United States." See 21 U.S.C. 1801(a). This required purpose does not include advertising gauged at affecting the outcome of a local ballot initiative.

- The statute also requires the Director to "use amounts made available to carry out this chapter that focuses on, or includes specific information on, prevention or treatment resources for consumers within specific local areas." 21 U.S.C. 1801(b). This requirement does not incorporate advertising gauged at affecting the outcome of a local ballot initiative.

- The statute similarly includes a section on authorized uses of the funds. For advertising, the statute provides that "the Director shall devote sufficient funds to the advertising portion of the national media campaign to meet the stated reach and frequency goals of the campaign." 21 U.S.C. 1802(a)(2).

  The reach and frequency for both youth and adult targets apply to advertising *that is consistent with the Communications Strategy*. The Strategy was provided to the ONDCP's Congressional Appropriators and Authorizers, as part of the requirements of the Media Campaign's original authorization, as incorporated into ONDCP's FY98 appropriation, P.L. 105-61.

  The Communications Strategy addresses the communications objectives for the parent/caregiver audiences. The (verbatim from the Strategy) objectives are:

  - (1) enhance perceptions of harm associated with adolescent use of marijuana and inhalants;
    - e.g., adolescents initiate drug use at earlier ages now than in the past, and the earlier an adolescent initiates drug use, the greater the likelihood that a serious problem will develop as a result.

  - (2) make parents aware that their children are at risk for using drugs and are vulnerable to the negative consequences of drug use;
    - e.g., address the problem that parents underestimate the probability that use of illicit drugs may be occurring in their family.

- (3) enhance perceptions of personal efficacy to prevent adolescent drug use (i.e., let parents know that their actions can make a difference);
  - e.g., provide persuasive assurances from credible sources that effective actions can be taken by any parent.

- (4) convey simple, effective parenting strategies including communication and family management skills that are known to help prevent adolescent drug use;
  - e.g., suggesting that parents establish and clearly communicate drug non-use expectations.

- (5) encourage specific community-focused actions;
  - e.g., taking action to support community anti-drug communities;

- (6) encourage parents who use psychoactive substances to consider the effects of their own substance abuse on their adolescents and other children.
  - e.g., impact parental behavior as role models.

- The mandate on the Director to expend appropriated funds on advertising to meet the targeted reach and frequency applies to the Communications Strategy, which the Congress has previously seen and approved. Affecting the voting patterns/behaviors of voting age adults and adult influencers is not among the communications objectives or strategies directed toward reducing youth drug use.

Mr. OSE. Let me go back for a minute. I want to make sure I understand on the smoked marijuana question whether or not we are doing clinical trials on smoked marijuana. Are we or are we not doing clinical trials on smoked marijuana for medical purposes?

Mr. SCHECTER. I am not aware of any plans in HHS to do that. In fact, they indicated yesterday that they probably would not go in that direction.

Mr. MILLSTEIN. The National Institutes of Health is supporting one study, a clinical study, looking at the affects of smoked marijuana.

It is a phase I safety study supported by five NIH Institutes, with Dr. Donald Abrams of the University of California at San Francisco; looking at the affects of smoked marijuana as it interacts with AIDS medications and protease inhibitors.

Mr. OSE. I am not a clinical diagnostician or anything like that, but I do read some. From what I read of smoked marijuana, it is a suppressant to the body's natural immune systems. Am I correct in my understanding?

Mr. MILLSTEIN. Yes.

Mr. OSE. What would be the purpose of a study that introduces a suppressant to immune systems in conjunction with the protease inhibitors that might be an enhancer? Are we talking about nullification of impact?

Mr. MILLSTEIN. There are a number of periods with marijuana in the smoked form; not only including the one you mentioned, Mr. Chairman, but also pulmonary effects. The study is looking at, as I said it is a phase I safety study.

If it turns out there is no safety, this would be a message that would go back to other people in your State about the negative effects of smoked marijuana.

Mr. OSE. There is information about the adverse impact of marijuana, as you say, for pulmonary reasons?

Mr. MILLSTEIN. Yes.

Mr. OSE. Well, if we know that, why are we studying it again?

Mr. MILLSTEIN. The fact is that many people are using marijuana because of, not scientific evidence, but anecdotal reports that it is effective.

Dr. Abrams is trying to show by having comparisons of different subjects using and not using; some using marijuana; some using the synthetic product, marinol, the zeltinyne tetrahydrocanavanol.

That is the one most psychoactive ingredient of marijuana and a placebo group to be able to make comparisons of the effects of all three groups.

Mr. OSE. I must say I do not understand why we have to do a study about something we already seem to know about.

Mr. MILLSTEIN. A lot of people do not believe what science says. They do not believe Government. Since I have decided that nothing is helping them and this will be actual activity, scientifically, to say what are the results in each group.

Mr. OSE. Are we advertising the results of the previous study that established the connection between adverse pulmonary impact and the use of marijuana as much as we are these other things within the ONDCP's advertisements? Are we relying on anecdotal transfer of the information?

Mr. MILLSTEIN. I do not know if that specific information is released in the ONDCP. In NIDA's own materials, including those targeted to middle school students, and in our brochures, Marijuana Affects Appearance and Marijuana Affects Routines, we speak about marijuana and its negative effects.

We have people who are saying that nothing helps them. That they are terminally ill. That they do not care about certain affects on their body because of the alternatives that they are facing. This will be the first ever scientific study that will show differences. This is in an AIDS population.

Mr. OSE. I have one more question on the marijuana aspects of this. Mr. Cummings, do you have a question?

Mr. CUMMINGS. Yes.

Mr. OSE. I will gladly yield to you.

Mr. CUMMINGS. Thank you very much.

Mrs. MINK. Your time is up.

Mr. OSE. My time is up?

Mrs. MINK. Yes.

Mr. OSE. OK.

Mr. CUMMINGS. I was just looking at this document of grants. First of all, thank you. It is nice to know that Maryland is getting money.

Mrs. MINK. How much?

Mr. CUMMINGS. Quite a bit. I am just curious. When I look at these grants, I am trying to figure out if they have proposals and they present them to you? Is that it? They do not look like something that you sort of put an RFP out for. Is that how it goes?

Dr. AUTRY. There basically are two types of grants. One are what are called Block Grants or Formula Grants. These are given on a capitation basis to the States, both in the mental health and substance abuse, treatment, and prevention area.

In the substance abuse, treatment, and prevention area, that money goes directly to the State, the Single State Authority, working with the Governor who then dispenses that; 80 percent for treatment, 20 percent for prevention.

In addition to the Block Grants, there are what are called Discretionary Grant Programs which are competitively awarded where we solicit ideas in certain areas based on input from the field, put out what are called GFAs or Guidance For Applicants, who apply for the funds. They are competitively reviewed and then hopefully awarded. Those are the two basic types of grant programs.

Mr. CUMMINGS. I mean are there some goals that you have?

Dr. AUTRY. You were not here at the opening statement. One of the things that I said is that every time we have a program that we start, we have not only specific evaluation outcome and process goals for the individual projects that are funded in these programs, but also for the overall program as a whole.

So, we look at how effective it was, say, a new substance treatment intervention program, as a case in point.

Mr. CUMMINGS. OK. Mr. Schecter, Chairman Mica, when he was here, was talking about his little focus group; talking about the ads. It is interesting. When General McCaffrey first instituted this program, he came to Baltimore.

He spoke at a high school which is located in the inner city. Most of these kids are very street-wise. Most of them have either had a relative, or they know of someone who was close to them, who have died indirectly or directly because of drugs.

So, this is a pretty street-wise group. One of the interesting things is that they played several of the ads. The one which seemed to really hit them hard was the frying pan ad, where the woman takes an egg and she is splattering stuff all over the place. Are you familiar?

Mr. SCHECTER. Yes. In fact, that is a heroin ad.

Mr. CUMMINGS. Is it heroin?

Mr. SCHECTER. Yes.

Mr. CUMMINGS. I am just wondering, how do you all rate those ads? It was so interesting. When I talk to kids about these ads, out of all of the ads that they see on television, I will bet you that one rates about 95 percent.

That is the one they seem to remember and say has some impact on them. There are a lot of them. I mean I have seen so many of them. I was just wondering how you rate them.

Mr. SCHECTER. Mr. Cummings I have to share with you that "frying pan" is my personal favorite among the ads. But we do not want to run this campaign based on what ads you, I, or anybody else thinks are most effective.

One of the unusual things about this campaign is that we have set-up a very rigorous ad testing process that involves focus groups put together by people whose business it is to test ads much the way General Motors would before launching a $500 million ad campaign.

They do not want to spend money on ads if they are not going to work. So, we are doing the same thing. We want to make sure that any ad that is aired, before it will air as a part of this campaign, has undergone a rigorous ad testing process. It has to be shown to be effective with its particular target audience.

Mr. CUMMINGS. About how many ads do you have out there? Do you have any idea?

Mr. SCHECTER. I am not sure what the number is. Right now it is probably 50 or 60 different ads.

Mr. CUMMINGS. I guess what I am trying to get to is as I understood the program, they were trying to figure out, they were doing little testing and they were trying to figure out in the first quarter or whatever, what kind of effect they were having.

I am just wondering, do you then pick like the top 10, or top 15, or something like that. I mean how does that work or do you just continue. I am going to what you just said. I agree with you.

I mean we, in Government, I think on both sides of the aisle want taxpayers' money to be spent effectively and cost efficiently. So, I am just wondering do you take your top 10 or your 15, or do you just keep—staff gave you something.

Do you keep just running ads that do not even—I guess what I am thinking about is the way they do the television ratings. If a show does not do well——

Mr. SCHECTER. Either it is effective or it is not effective.

Mr. CUMMINGS. Right.

Mr. SCHECTER. That is really the threshold. If it is not effective, it is not used anywhere in our campaign. In fact, when we subjected the first round of available ads produced through the Partnership For Drug Free America, and they are the best in the business in this kind of thing, what we found was that some of the ads did not work.

You or I may not have guessed that. It may have seemed to you or I like a great ad, but this was an ad targeted to a 10 or 12 year old kid. It is not important whether you or I think it is a good ad.

Does it achieve the desired effect with that young person? So, some of the ads were discarded. I would also mention that, particularly now that we are starting to approach phase III which will begin this summer, we are going to have much more targeted and differentiated kinds of ads.

We are developing ads in 11 different foreign languages; ads targeted to all sorts of different ethnic groups so that no matter what the community is, we will have tested ads that will be effective with that particular group.

Mr. CUMMINGS. One last question. It is so interesting. I notice that a lot of times they will run two or three of these ads right in a row. Why is that?

Maybe this is not a national thing. In Maryland, I have noticed that a lot of times, they will run them and they will run them right behind each other. I thought maybe that was one of your theories of effectiveness or something.

Mr. SCHECTER. No. I do not think there is any particular purpose there. Sometimes what that means is that you have got a paid ad and then maybe a pro bono matching ad right behind it.

So, the network of the local station will simply just tag those together. I have seen that done, incidently, for other product ads as well, not just our campaign.

Mr. CUMMINGS. Thank you.

Mr. OSE. Mrs. Mink.

Mrs. MINK. So, which is the most effective ad you have produced?

Mr. SCHECTER. I do not think I could answer that. Again, it is not a ranking. It is a threshold of effectiveness that must be met.

Mrs. MINK. Does the fried egg make it?

Mr. SCHECTER. Oh yes, absolutely. That is why you see it. As I said, it is my own personal sentimental favorite.

Mrs. MINK. Thank you.

Mr. OSE. One last observation. I am not all that skilled at the legislation that this subcommittee has jurisdiction over.

I would wager that the legislation that this subcommittee did authorize does not include a restriction on targeting of ads into specific areas in such a way as to off-set what might be a concentration of pro-marijuana use in a political campaign.

I just have a hint or an inkling of that. The reason I keep coming back to this is No. 1, I have been the beneficiary of some very creative advertising and the subject of some other creative advertising. I know it works.

While I am not in any way, shape or form suggesting that this gentleman should be noted for anything else, but Pat Buchanan said, you know, when you hear the gun fire, do not call headquarters. Mount up and ride to the sound of the gun fire.

We have five States right now, if not more who are considering referenda to legalize the use of marijuana for medicinal purposes, if not otherwise. I do not see any reason not to go and engage in that debate.

I thank my colleagues. You have been very patient to this rookie.

Mr. CUMMINGS. I know a lot about marijuana, Mr. Chairman. I have heard more about marijuana today than I have heard in years, Mr. Chairman.

Mr. OSE. I thank the witnesses.

We would like to leave the record open for 2 weeks for members' submission of questions.

I look forward to future briefings.

We are adjourned.

[Whereupon, at 3:15 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

U.S. Department of Justice

Office of Justice Programs

National Institute of Justice

Office of the Director

Washington, D.C. 20531

Statement for the Record

Criminal Justice, Drug Policy and Human Resources Subcommittee

Committee on Government Reform

House of Representatives

on

The National Institute of Justice's

Drugs and Crime Research Programs

by

Jeremy Travis

Director, National Institute of Justice

Office of Justice Programs

U.S. Department of Justice

March 18, 1999

Over the years, the National Institute of Justice (NIJ) has sponsored research and supported demonstration programs to develop a deeper understanding of the nexus between drug abuse and crime. NIJ's objective is to build knowledge that will assist policymakers and practitioners in understanding this relationship and to develop strategies that hold promise to break the cycle between drug abuse and crime. Much has been learned from research and practice, enabling state and local governments to design strategies and specific interventions that reduce crime and lower drug abuse.

This statement highlights NIJ's recent and ongoing efforts to research the scope and nature of crime related to drug abuse and NIJ's programs in the field that support this research by providing "real world" experience with programs designed to reduce drug abuse and its concomitant crime. Many of NIJ's efforts have been performed in collaboration with other federal agencies -- such as the Office of National Drug Control Policy, the National Institute of Drug Abuse, and other Office of Justice Program organizations, such as the Drug Courts Program Office and the Corrections Program Office. NIJ and its grantees also work closely with the state and local governments and communities that have the principle responsibility and capacity to reduce drug abuse and crime.

NIJ, a component of the Office of Justice Programs, U.S. Department of Justice, was created by the Omnibus Crime Control and Safe Streets Act of 1968, as amended. NIJ is authorized to support research, evaluation, and demonstration programs; technology development; and both national and international information dissemination. Specific mandates of the Act direct NIJ to focus its efforts on strengthening and improving criminal justice and

preventing crime and delinquency. The Office of Justice Programs, headed by Assistant Attorney General Laurie Robinson, also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and six program offices.

Drug abuse is an established and well-documented characteristic of a substantial proportion of persons who come into contact with the criminal justice system--regardless of the type of offense. According to data from NIJ's Arrestee Drug Abuse Monitoring (ADAM) program, which is described below:

> Drug use is widespread among those arrested. Between 51 and 80 percent of arrested adult males test positive for drugs and between 41 and 65 percent of arrested juvenile males test positive.
>
> Older arrestees are testing positive for cocaine at 2 to 10 times the rate of the younger arrestees. In Washington, D.C., and Detroit, for example, approximately 5 percent of 15- to 20-year-old arrestees test positive for cocaine compared with 50 percent for arrestees who are 36 years old and older.
>
> Marijuana use among arrestees continues to be disproportionately concentrated among youthful offenders, but 1997 data also show that marijuana use among youthful arrestees is leveling off and in some cities decreasing noticeably. Generally, rates of positive test results for marijuana use among juvenile male arrestees who have left school without graduating range from 3 to 30 percentage points higher than rates for juvenile males still in school.

Surveys of prisoners confirm that substance abuse is implicated in criminal activity. Data from the 1997 survey of inmates in federal and state prisons by the Bureau of Justice Statistics (BJS) show that three-quarters of all prisoners can be characterized as drug- or alcohol-involved offenders. Over half of state inmates (52 percent) and over one-third (34 percent) of federal inmates reported committing their current offense under the influence of drugs or alcohol. For those incarcerated for a violent offense, 40 percent of federal inmates and 52 percent of state inmates reported use of drugs or alcohol at the time they committed the offense for which they were incarcerated.

Through NIJ research, we are starting to understand that the drug users coming through the criminal justice system are not casual users, but highly dependent upon illegal substances. Nor is this a population that has frequently sought treatment in the past; only 25 percent of drug users in prison were previously in treatment and, according to a New York City study of addicts, 70 percent have neither been in treatment nor intend to seek treatment. A 1995 NIJ research report indicated that between 60 and 75 percent of untreated parolees who have histories of heroin and/or cocaine use return to those drugs within three months after release.

The problem is further compounded by the fact that the greatest proportion of offenders with drug abuse problems are, in fact, not incarcerated in prisons and jails, but under some form of community supervision (probation, parole, and/or in a community corrections setting). There are about 3.9 million adult men and women on probation or parole in communities, more than twice as many as the 1.25 million incarcerated in state and federal prisons and the 600,000 in local jails. BJS data show a large proportion (43 percent) of probationers under community supervision regularly used illicit drugs prior to their current offense. Yet community corrections

programs often lack sufficient authority and resources to effectively respond to the problem of drug abuse.

Research has shown that when drug abuse testing is combined with effective interventions--such as meaningful, graduated sanctions or various treatment programs--drug abuse can be curtailed within the criminal justice population. Recent studies demonstrate that drug-dependent individuals who receive comprehensive treatment decrease their drug use, decrease their criminal behavior, increase their employment, improve their social and interpersonal functioning, and improve their physical health. Moreover, when compared to drug abusers who voluntarily enter treatment, those coerced into treatment through the criminal justice system are just as likely to succeed.

Studies also show that treatment is cost-effective. In 1994, the RAND Corporation reported that drug treatment is the most cost-effective drug control intervention. Another 1994 study examined a comprehensive drug and alcohol treatment program in California and concluded that for every dollar invested in drug treatment, the taxpayers saved $7. Savings were attributable to decreased use of drugs and alcohol and the resulting reduction in costs related to crime and health care.

Since its founding in 1987, NIJ's ADAM program (formerly known as the Drug Use Forecasting program)s generated data at the local level that have played an important role in helping state and local policymakers, as well as researchers, understand the links between drugs and crime. ADAM data have also helped construct the national picture of drug abuse.

Four times per year, in 35 major urban areas nationwide, with plans for expansion dependent upon additional appropriations, ADAM staff interview and collect urine samples from

arrestees to detect and evaluate recent drug use. Using this data, researchers examine the relationship between drugs and violent crime, overdoses and other drug-related medical emergencies, gun use and attitudes toward guns among arrestees, and arrestees' need for drug treatment. Researchers have already used the program's data to analyze variations in the purchase and use of powder cocaine, crack, and heroin; and access to and use of illegal firearms by arrestees. Data from a number of participating ADAM jurisdictions were a key element in illuminating and analyzing the links between drug activity and homicide rates revealed in NIJ's December 1997 "Homicide in Eight U.S. Cities" research report.

In addition, in the future, the ADAM program will permit testing for a broader range of drugs and health threats by making additional drugs and certain sexually transmitted diseases part of the quarterly testing protocol. ADAM will accommodate the needs of local researchers and policymakers through specialized questionnaires developed for specific purposes. In this way, federal agencies (such as the Drug Enforcement Administration and the National Institute on Drug Abuse), U.S. Attorneys, and local organizations partner with the ADAM program to collect data from arrestees on an array of timely questions in specific areas or regions of the country.

For example, NIJ and researchers at the University of Missouri - St. Louis are currently developing a supplemental questionnaire on gangs and gang activity. Also, several countries have expressed interest in establishing their own programs modeled on ADAM. For example, England has completed a pilot project, and Australia, Scotland, Chile and South Africa are now moving forward with plans to adopt such a program. International sites could provide baseline information about drug abuse problems throughout the world and serve as a foundation for conducting comparative research on criminal justice policies and drug abuse.

Criminal justice professionals are often the first to point out that they have been operating a "revolving door" by which drug-using defendants, left untreated, are sooner or later returned to their communities, only to fall back into the old patterns of behavior that originally contributed to their troubles. By contrast, use of treatment-oriented drug courts appears to convert arrests of drug-dependent individuals into opportunities to intervene, which can generate favorable outcomes if intervention is accompanied by accountability, treatment, encouragement, and support.

In fiscal year 1997, NIJ launched a demonstration project—Breaking the Cycle (BTC)—in Birmingham, Alabama to apply research findings indicating that when the coercive power of the criminal justice system is used to reinforce drug abuse treatment, defendants are more likely to change their behavior. The project fully integrates system-wide drug testing, referral to treatment, judicial supervision of treatment, and graduated sanctions throughout pretrial and post-conviction processes. In this way, BTC expands the criminal justice system's focus beyond the resolution of traditional legal issues. BTC deals with a factor discovered at arrest that commonly contributes to criminal behavior— substance abuse.

BTC is funded by the Office of National Drug Control Policy and developed in collaboration with NIJ, the Bureau of Justice Assistance, the Office of Juvenile Justice and Delinquency Prevention, the Drug Courts Program Office, the Corrections Program Office, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment. In Birmingham, BTC is currently targeted to all felony arrestees who are identified as drug users (except certain violent offenders) and approximately 5,000 defendants have been or are now

enrolled in the project. All participants receive case management services and all are monitored by the court.

BTC is designed to answer a key question: What would be the impact on the incidence of drug use and crime in a given community if all arrested drug users could be identified early, assessed for their drug treatment needs, referred to appropriate drug treatment, monitored through regular drug testing, and sanctioned immediately if pretrial drug use occurs?

Specific BTC objectives include:

Close collaboration between criminal justice and drug treatment professionals. BTC envisions that every drug-using defendant entering the criminal justice system—regardless of offense or likely case outcome—will be assessed by an organization that is an advocate for neither defense nor prosecution. Treatment is ordered by the court and individualized treatment plans are written. Judicial supervision takes the form of reviews of defendants' treatment participation or drug testing results at each court appearance.

Early intervention. BTC calls for identifying eligible subjects for drug treatment immediately after arrest, perhaps the most propitious moment to intervene. Drug testing occurs before the initial court appearance and is followed within 24 hours by a clinical assessment and appropriate treatment.

Judicial oversight. BTC involves regular drug tests and close judicial oversight of drug treatment. Judges have broad authority to impose and enforce pretrial conditions that address public safety. This requires that judges have speedy access to compliance information, so they can review drug test results and treatment participation at each

scheduled court hearing.

Use of graduated sanctions and incentives. Judges review the progress of drug-abusing offenders and steadily apply leverage—both sanctions and incentives—to keep offenders in treatment and off drugs. Sanctions are graduated, and certainty in their application is more important than severity of consequences. They are imposed as soon as possible after a violation of judicial orders occurs.

BTC is being evaluated to determine its impact in four key areas: lowering drug use among offenders; reducing criminal behavior among offenders; improving indicators of social functioning, such as employment and health; and making more effective use of criminal justice resources, especially detention capacity. What is known so far is that BTC has allowed Birmingham to identify drug-using defendants within 48 hours of arrest on average, compared to the six months before the initiative began. There are more treatment options and space available and defendants stay in these interventions longer, helping to sustain abstinence. For the first time, there are immediate and meaningful administrative and judicial responses to defendant behavior. In addition, the collaboration engendered by BTC has helped the jurisdiction to address other criminal justice issues, such as jail crowding and case processing. For example, alternative programs to pretrial detention and case processing innovations created by the BTC Advisory Committee have helped lower the local jail's population by about 200 detainees.

Recently, NIJ and the Office of National Drug Control Policy expanded BTC to the adult justice systems of Jacksonville, Florida, and Tacoma, Washington, and the juvenile justice system of Lane County (Eugene), Oregon.

As noted above, many incarcerated offenders have a history of drug use that has often contributed to criminal behavior resulting in imprisonment. Designed to help break the cycle between drugs and crime, the Residential Substance Abuse Treatment program (RSAT) in correctional facilities seeks to motivate and help these offenders overcome drug involvement and, thereby, reduce subsequent crime.

The Violent Crime Control and Law Enforcement Act of 1994 authorizes programs that support both treatment of and sanctions for drug-using and violent offenders. Several evaluations of corrections-based substance abuse treatment programs provide evidence of significant reductions in recidivism rates among chronic drug-abusing felons.

In addition, in 1997, Congress mandated that states implement comprehensive programs of drug testing, sanctions, and treatment by September 1, 1998. By that date, all 50 states had submitted those strategies to the Justice Department.

The Residential Substance Abuse Treatment for State Prisoners Formula Grant Program addresses the treatment goal by providing formula grants to states to develop and implement residential substance abuse treatment programs within state and local correctional facilities where inmates are incarcerated for sufficient time to permit substance abuse treatment (typically 6-12 months). States are encouraged to adopt comprehensive approaches to substance abuse treatment for offenders, including relapse prevention and aftercare services. Encompassing different regions of the nation, programs span a broad spectrum: programs for adults and juveniles (males and females), those that operate in state correctional facilities or local jails, and programs based on different theoretical approaches. Each program operates in a residential treatment facility set

apart from the general correctional population; that is, the treatment facility either is in a location outside the confines of the prison or jail containing the general correctional population or is within a prison or jail but in a housing unit for exclusive use by program participants. Ideally, each program limits participants to inmates who have 6 to 12 months remaining in their confinement terms so that they can be released into the community directly after completing their treatment rather than returned to the general prison population.

Since FY 1997, the states, the District of Columbia, and eligible territories have received just over $111.8 million in RSAT funds to implement the program. Recent research and evaluations show consistent reductions in recidivism rates for offenders completing treatment programs. Successful outcomes are tied to length of time in treatment (at least six months) and provision of continued treatment in the community after release. Programs that address the myriad problems associated with the lifestyle of substance use and addiction are the most effective. For example, of the offenders in the Delaware Therapeutic Continuum Program who completed the in-prison therapeutic community treatment and the after-prison work release programs, 75 percent were drug-free and 70 percent were arrest-free after 18 months, compared to 17 percent drug-free and 36 percent arrest-free among the control group.

The Office of Justice Programs' Corrections Program Office (CPO) administers the RSAT Formula Grant Program and has contributed to the planning and development of NIJ's RSAT evaluation portfolio. The NIJ/CPO partnership reflects both agencies' commitment to fostering practitioner/researcher partnerships, building a relevant and timely knowledge base, and improving corrections and other related programs.

An important element of NIJ's RSAT evaluation portfolio consists of local evaluations of

individual RSAT programs. Requiring collaboration among researchers, corrections officials, and program administrators, local RSAT process evaluations are under way or are about to start in 15 States. Local evaluations are initially focused on process—the implementation and operation of RSAT programs. However, independent local evaluators, in partnership with corrections officials, will be able to compete for additional funding to study the RSAT program's impact on substance use and criminal behavior. NIJ's evaluation efforts also include a national evaluation, designed to augment and complement the local evaluations. The national evaluation has a broader focus than the evaluations of specific RSAT programs and includes surveys of all State corrections officials, institutional administrators, and RSAT program directors. The national assessment should provide broad information on how RSAT funds were spent and to what effect.

Drug courts represent a promising initiative that uses the coercive authority of the courts, in conjunction with testing, treatment, and sanctions, to change behavior. In 1989, a few communities began experimenting with an approach to address the needs of drug-abusing offenders that integrated drug abuse treatment, sanctions, and incentives with case processing to place nonviolent drug-involved defendants in judicially supervised rehabilitation programs. Now, nationally more than 530 courts have implemented or are planning to implement a drug court to address the problems of drug abuse and crime. Local coalitions of judges, prosecutors, attorneys, treatment professionals, law enforcement officials, and others are using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs to teach responsibility and to help offenders reenter the community.

OJP's Drug Courts Program Office administers the Drug Courts Grant Program, which

was authorized by the 1994 Crime Law. Since Fiscal Year 1995, the Drug Courts Program Office has awarded more than $95 million to approximately 500 jurisdictions for the planning, implementation, and enhancement of drug courts. In the same period, they awarded grants totaling $2.9 million to Native American communities for planning and implementation of tribal drug courts. An additional $40 million in grant awards will be made later this year. To support these grant awards and other requests, the Drug Courts Program Office has also responded to more than 1700 requests for technical assistance.

A 1998 report prepared by the Drug Court Clearinghouse and Technical Assistance Project outlines the progress made in the first decade of the drug court movement. In that ten-year span, close to 100,000 drug-dependent offenders entered drug court programs and more than 70 percent are either still enrolled or have graduated–more than double the rate of traditional treatment program retention rates. Drug court participants reflect all segments of the community, with men participating at more than twice the rate of women, although the percentage of females is rising. Most participants have been using drugs for many, many years, and many use multiple types of drugs. Most have never been exposed to treatment, although a large majority have already served jail or prison time for drug-related offenses.

Unlike traditional treatment programs, becoming "clean and sober" is only the first step toward graduating from drug court. Many require participants to complete a high school education, maintain employment, be current in financial obligations, have a sponsor in the community, and perform community service.

The original goals for drug courts–reductions in recidivism and drug usage–are being achieved, with recidivism rates substantially reduced for graduates and, to a lesser but significant

degree, for participants who do not graduate as well. The "outcomes" that drug courts are achieving go far beyond these original goals. Some of these "outcomes" include: the birth of more than 500 drug-free babies to drug court participants; the reunification of hundreds of families, as parents regain or are able to retain custody of their children; education and vocational training and job placements for participants.

The Office of Justice Programs' Drug Court Grant Program is responsive to and supportive of developments in the field, including the need for conducting both process and outcome evaluations. NIJ, with funding from the Drug Courts Program Office, has initiated evaluations of drug courts and a demonstration project in the District of Columbia Superior Court.

In summary, drug-involved offenders place a heavy toll on our country's criminal justice systems. Their numbers swell our courts, crowd our prisons, and tax our probation and parole programs. Where not detected or effectively dealt with their first time around, many of these drug-involved individuals will find their way back into the criminal justice system--again and again. Thus, NIJ and other agencies have focused research, evaluation, and demonstration programs on substance abuse testing and intervention efforts aimed at individuals under criminal justice supervision as a way of reducing citizens' demand for illegal drugs and the terrible consequences to individuals, families, and communities of drug abuse. Much has been learned from research and practice, enabling state and local governments, often with federal assistance, to design strategies and specific interventions that reduce drug-related crime and drug abuse.

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